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;

LARRY A. BURNS, D.O., on behalf of himself, his staff, and his patients; and

COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, INC., on behalf of itself, its physicians and staff, and its patients,

Plaintiffs,

v.

J. KEVIN STITT, *in his official capacity as* Governor of Oklahoma,

MIKE HUNTER, *in his official capacity as* Attorney General of the State of Oklahoma;

DAVID PRATER, *in his official capacity as* District Attorney for Oklahoma County;

GREG MASHBURN, *in his official capacity as* District Attorney for Cleveland County

GARY COX, *in his official capacity as* Oklahoma Commissioner of Health; and

MARK GOWER, *in his official capacity as* Director of the Oklahoma Department of Emergency Management,

Defendants.

Case No: 20-CV-277-G

DEFENDANTS' RESPONSE IN OPPOSITION TO PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION

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INTRODUCTION

We are facing the public health crisis of our generation. The State of Oklahoma—along with the rest of the country and the world—has taken strong measures to preserve the public health. The well-known strategy has been to "flatten the curve": slow the spread of the virus and preserve our healthcare resources such that the peak infection rate does not outstrip our system's ability to treat patients. This requires everyone—cumulatively, throughout society—to participate, and our democracy has tasked state elected officials to coordinate and enforce this life-saving public health response.

In pursuing this strategy, Oklahoma has taken numerous steps: it has shuttered businesses, halted commerce, restricted movement and travel, delayed democratic processes, prohibited assembly and gatherings over 10 people, and pushed back criminal trials. All of these acts implicate constitutional liberties, but precedent firmly establishes that it is within the State's police power to do so to protect the public health.

After numerous doctors and healthcare organizations made strong recommendations, the Governor also imposed a temporary delay on elective procedures. This delay, like many other measures, will reduce the risks of further spread of the virus, preserve personal protective equipment (PPE), and, in the event of complications from elective procedures, preserve the availability of hospital resources in the near term for when the virus's worst impact is upon us.

Plaintiffs admit the pandemic is a public health emergency. Doc. 16 at 4. Their motion does not claim they are being treated differently from others. Plaintiffs admit they have a large role to play in limiting the virus's spread and preserving our state's healthcare resources. *Id.* at 12. They just refuse to do so. That should suffice to show their claims must fail.

But in their view, while Oklahoma can fight the pandemic in numerous ways that implicate constitutional liberties—assembly, speedy trial, travel, commerce, property—the Constitution absolutely forbids postponing elective abortions even if doing so helps protect the public health. *Id.* at 18-21. In their view, every elective procedure throughout the state can be delayed, but elective abortion must go unaffected, no matter what. And in their view, our elective representatives have no right to manage the public health response to this pandemic, but instead each individual business, provider, and patient should do what they want, no matter the toll imposed on everyone else. *Id.* at 29.

The Constitution does not require Plaintiffs' novel and potentially devastating view. That is why the highest court to have ruled on the matter—the Fifth Circuit—has allowed a similar elective procedure delay to go into effect. *See In re Gregg Abbott, et al.*, No. 20-50264 (5th Cir. Mar. 31, 2020). Oklahoma has required a temporary *delay*—not a ban—of elective procedures, including abortions, as part of a legitimate overall strategy to reduce strain on our healthcare system during a global pandemic. The Supreme Court and other courts have repeatedly affirmed such acts throughout our history. Nothing in Supreme Court precedent states that abortion is uniquely exempt from that which applies to all other elective procedures, nor does anything in law hold abortion as the sole absolute constitutional right, above all other rights. Abortion, like all other procedures and rights, are subject to reasonable health regulations.

There is no question that Oklahoma is acting within the bounds of reason when it seeks delay of elective procedures during this pandemic. This Court must reject Plaintiffs' attempt to interfere with the State's ability to reasonably manage this public health crisis. Undermining our ability to do so jeopardizes everything.

STATEMENT OF FACTS

A. The COVID-19 pandemic and the public health response to "flatten the curve."

COVID-19 is an exponentially increasing health threat to the entire world. As of April 2, 2020, COVID-19 has infected 962,927 people and caused 49,180 deaths.[1] The United States alone has 188,547 confirmed cases, with 64,000 cases confirmed just since March 29. Oklahoma has been experiencing a similar exponential increase: in the past two weeks, the state went from 17 cases and 0 deaths to 719 cases and 30 deaths.[2]

This is a once-in-a-century public health emergency. A study from the Imperial College of London predicted that the U.S. would suffer high fatalities without decisive action.[3] Italy delayed, and within a few weeks, its healthcare system was forced to ration care based on who was most likely to survive.[4] Wait times for intensive care beds are hours long, older patients "are not being resuscitated and die alone without appropriate palliative care," hospitals are overcrowded, and medications, ventilators, and personal protective equipment ("PPE") are unavailable.[5] Italian cemeteries are overwhelmed from all of the deaths.[6]

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[1] Coronavirus COVID-19 Global Cases by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU), https://gisanddata.maps.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6 (accessed Apr. 2, 2020).

[2] Oklahoma COVID-19 Timeline, https://coronavirus.health.ok.gov/.

[3] Sheri Fink, *White House Takes New Line After Dire Report On Death Toll*, (N.Y. Times, Mar. 16, 2020), https://www.nytimes.com/2020/03/16/us/coronavirus-fatalityrate-white-house.html.

[4] Mattia Ferraresi, *A Coronavirus Cautionary Tale From Italy: Don't Do What We Did*, (Boston Globe, Mar. 13, 2020), https://www.bostonglobe.com/2020/03/13/opinion/coronavirus-cautionary-tale-italy-dont-do-what-we-did/

[5] Mirco Nacoti, et al, *At the Epicenter of the Covid-19 Pandemic and Humanitarian Crises in Italy: Changing Perspectives on Preparation and Mitigation*, NEJM Catalyst: Innovations in Care Delivery, Mar. 22, 2020), https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0080.

[6] *See id.*

Some areas of the U.S. are already at risk of being overwhelmed by the epidemic. New York City alone has 83,889 of the COVID-19 cases in the United States.[7] It had 281 deaths from COVID-19 as of March 27,[8] 1,096 deaths as of March 31,[9] and 1,941 deaths as of April 2.[10] Medical staff are rationing limited PPE due to the large volume of cases while medical facilities acquire refrigerated trucks to use as temporary morgues for the overwhelming number of deaths.[11] Louisiana is rapidly approaching a similar crisis, with PPE lacking while the COVID-19 cases increase.[12] Its state health experts estimate that it will have more sick patients than hospital beds by next week.[13]

The consensus public health response is now all-too-familiar: we must "flatten the curve." This strategy involves slowing the rate of new infections so that health services are not overwhelmed by the number of patients.[14] It also allows us time to manufacture more medical

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[7] Coronavirus Disease Daily Data Study, https://www1.nyc.gov/assets/doh/downloads/pdf/imm/ covid-19-daily-data-summary.pdf (as of Mar. 31, 2020 at 4:30 PM).

[8] *See* Bernard Condon, *Video Shows New York City Emergency Room Overflowing With Patients as City on Frontlines of Coronavirus Outbreak*, Associated Press, Mar. 28, 2020, https://abc7ny.com/jamaica-hospitalqueens-new-york-city-nyc-coronavirus/6058195/.

[9] Coronavirus COVID-19 Global Cases, *supra* note 1.

[10] Coronavirus in the U.S.: Latest Map and Case Count, N.Y. Times (as of April 2, 2020, 9:03 A.M. E.T.) https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html.

[11] Condon, *supra* note 8.

[12] Andrea Gallo, *Louisiana Nurses Face Start Choice Between Personal Protection, Coronavirus Patient Care*, https://www.nola.com/news/coronavirus/article_5ffada98-7071-11ea-9c12-0bbed00fccd5.html.

[13] Rosemary Westwood, *'This Is Absolutely Frightening': Louisiana Hospitals Brace For The Worst of COVID-19*, https://www.wwno.org/post/absolutely-frightening-louisiana-hospitals-brace-worst-covid-19.

[14] Interview with Dr. Drew Harris of Thomas Jefferson University, NPR, Mar. 11, 2020, https://www.npr.org/2020/03/11/814603316/public-health-experts-encourage-social-distancing-to-flatten-the-curve-of-infect.

equipment and PPE. As White House health advisor Dr. Anthony Fauci has explained, "You need to see the trajectory of the curve start to come down" before the country "can start thinking about getting back to some degree of normality."[15] Short-term restrictions on the populace impede viral spread and depletion of health resources such that the virus peaks at a level our healthcare system can handle. Then in the medium-term—after the peak—we can begin to relax restrictions as our system is able to handle more COVID and non-COVID medical care because of both fewer severe COVID-19 cases and higher supplies of newly-manufactured health resources (such as PPE). *See* Ex. 1, Loughridge Decl., ¶¶ 3-8, 12.

Governor Stitt has been following that strategy to prevent the epidemic from overwhelming our state's health services. *Id.* He declared an emergency in the state on March 15.[16] By March 24, he had issued an order limiting gatherings in the state to no more than 10 people, prohibiting visitations to nursing homes and long-term care facilities, and postponing all elective surgeries, minor medical procedures, and non-emergency dental procedures.[17] He also ordered the closing of all bars and the closing of dining-in areas at all restaurants, as well as the closing of all businesses that were not essential.[18]

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[15] Dan Mangan, *Fauci tells basketball star Stephen Curry US 'can start thinking about' getting back to normal when pandemic curve falls*, CNBC, Mar. 26, 2020, https://www.cnbc.com/2020/03/26/coronavirus-response-fauci-says-return-to-normal-ways-off.html.

[16] Executive Order 2020-07, Mar. 15, 2020, https://www.sos.ok.gov/documents/executive/1913.pdf.

[17] Fourth Amended Executive Order 2020-07, Mar. 24, 2020, https://www.sos.ok.gov/documents/executive/1919.pdf.

[18] *See* Seventh Amended Executive Order, 2020-07, April 1, 2020, https://www.sos.ok.gov/documents/executive/1926.pdf.

All of these strategies allow the health system to have capacity to address the virus's peak by both slowing viral spread and preserving health care resources such as hospital beds and PPE.[19] Though Plaintiffs appear to minimize this crisis, some hospitals in Oklahoma are already running short of PPE, and the need statewide is only expected to grow exponentially. Ex. 1, Loughridge Decl., ¶¶ 8-12; Ex. 2, Mareshie Decl. ¶¶ 4, 7; Ex. 3, Haney Decl. ¶¶ 8-9.

This is a broad strategy for a society-wide crisis. Everyone must pitch in, everyone must be subject to it, and every little bit helps. The postponement of elective procedures both limits interpersonal contact necessarily attendant to such procedures (preventing spread of the virus) and preserves medical resources (allowing greater capacity for when the virus peaks). Ex. 3, Haney Decl. ¶¶ 5-9. Any one procedure or class of procedure may always be argued to have limited impact, but cumulatively they put an unnecessary short-term strain on our healthcare system when it is most vulnerable. Ex. 2, Mareshie Decl. ¶ 8; Ex. 3, Haney Decl. ¶ 12.

Plaintiffs baldly accuse Oklahoma of "exploit[ing]" the pandemic all in order "to ban abortion services," but provide no evidence for this allegation. Doc. 16 at 1. Rather, the decision to postpone elective procedures came out of strong advocacy to the Governor by Oklahoma doctors and medical associations, including on television and a full-page ad in the *The Oklahoman* and *Tulsa World* demanding: "**Postpone Elective Surgeries Now!**" Ex. 3, Haney Decl. ¶¶ 4-6. Healthcare facilities around the state were already doing so, and more followed suit after the Governor heard their call and issued the elective procedure postponement. *Id.* at ¶¶ 5-6, 11; Ex. 1, Loughridge Decl., ¶ 14. At a press conference on March

[19] Governor Stitt Clarifies Elective Surgeries and Procedures Suspended Under Executive Order, Press Release, Mar. 27, 2020, https://www.governor.ok.gov/articles/press_releases/governor-stitt-clarifies-elective-surgeries.

24, a reporter asked the Governor if abortion was included in "the definition of elective surgeries . . . under your order."[20] He responded that he had "not gotten into the granular detail" with his team yet on everything affected by the order.[21]

Almost all abortions are elective procedures. Ex. 4, Valley Decl., ¶ 12.[22] They are chosen for non-medical reasons, such as "conclud[ing] it is not the right time to become a parent or have additional children," furthering a "desire to pursue [an] education or career," a "lack [of] necessary financial resources" or a lack of "partner or familiar support or stability. Doc. 16-4 at ¶ 22; Doc. 16-6 at ¶ 12. Plaintiffs' own motion repeatedly discusses the "right to choose" or "a woman's choice," rather than discussing medical necessity. Doc. 16 at 18, 19, 20, 22.

After reviewing the details, Governor Stitt confirmed that his orders regarding all elective surgeries and minor medical procedures had no special exception for abortion services.[23] He also stated that the mandatory postponement "also includes routine dermatological, ophthalmological, and dental procedures, as well as most scheduled healthcare procedures such as orthopedic surgeries."[24] This was done because "[t]he rapid spread of COVID-19 has increased demands for hospital beds and has created a shortage of personal protective equipment (PPE) needed to protect health care professionals and stop transmission of the

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[20] Press Conference, 45:20-45:33, available at https://www.facebook.com/GovStitt/videos/347717132833192/.

[21] *Id.* at 45:33-46:04.

[22] *See 30,000 Physicians Respond to ACOG on* COVID19, Press Release, Am. Ass'n of Pro-Life Obstetricians & Gynecologists, https://aaplog.org/press-release-30000-physicians-respond-to-acog-on-covid19/.

[23] Governor Stitt Clarifies Elective Surgeries and Procedures Suspended Under Executive Order, Press Release, Mar. 27, 2020, https://www.governor.ok.gov/articles/press_releases/governor-stitt-clarifies-elective-surgeries.

[24] *Id.*

virus."[25] He also clarified that the order does not apply to abortions necessary to address a medical emergency or to prevent serious health risks to the unborn child's mother.[26] The decision to postpone elective abortions along with other elective procedures has been made by other states and has support from major medical groups.[27] On April 1, the Governor extended the elective procedure postponement to April 30, 2020.[28]

As a result of Oklahoma's elective procedure postponement many different types of procedures have been delayed. This includes "[t]otal joint replacements, ear tubes, sinus surgeries, tonsils and adenoids, elective hysterectomies, tubal ligations, vasectomies, plastic surgery, circumcisions, cataracts, dental procedures, chronic pain procedures, [and] elective spine surgeries for pain." Ex. 3, Haney Decl. ¶ 11. Elsewhere in the country, "cancer surgeries

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[25] *Id.*

[26] *See id.* The statement has a slight typo, omitting the final "A" from OKLA. STAT. tit. 63, § 1-738.1A. Per the statutory definition, a medical emergency is:

> the existence of any physical condition, not including any emotional, psychological, or mental condition, which a reasonably prudent physician, with knowledge of the case and treatment possibilities with respect to the medical conditions involved, would determine necessitates the immediate abortion of the pregnancy of the female to avert her death or to avert substantial and irreversible impairment of a major bodily function arising from continued pregnancy.

OKLA. STAT. tit. 63, § 1-738.1A(5). Much of this language is identical to the Pennsylvania definition of medical emergency upheld in *Casey*. 505 U.S. at 879-80. The "serious health risks" language is also already present in Oklahoma statutes. *See* OKLA. STAT. tit. 63, § 1-737.9(A).

[27] *See 30,000 Physicians Respond to ACOG on* COVID19, Press Release, Am. Ass'n of Pro-Life Obstetricians & Gynecologists, https://aaplog.org/press-release-30000-physicians-respond-to-acog-on-covid19/ (statement of organizations that are "representatives of over 30,000 physicians").

[28] Seventh Amended Executive Order, 2020-07, April 1, 2020, https://www.sos.ok.gov/documents/executive/1926.pdf.

are being delayed, many stent procedures for clogged arteries have been pushed back and infertility specialists were asked to postpone helping patients get pregnant."[29]

B. The risks of elective abortion during the COVID-19 pandemic.

Elective abortion—like many other elective procedures—poses at least three short-term risks to the healthcare system during this most crucial time: it requires interpersonal contact increasing the risk of viral spread, it increases the use of PPE, and it increases the risk that more persons will require hospital beds in the short-term as a result of complications. As abortionists in Oklahoma tell their own patients, women undergoing an abortion risk experiencing allergic reactions to anesthetics or medications, bleeding, infection, laceration of the cervix, perforation of the uterus, injury to internal organs, blood clots in the legs, pelvis, or lungs, severe emotional reactions, hemorrhage, and death. *See* Ex. 5.

Women may obtain an abortion by medication or surgery. *Gonzales v. Carhart*, 550 U.S. 124, 134 (2007). Plaintiffs have, for the purposes of this case, re-labeled what is commonly called a "surgical abortion" into a "procedural abortion." Doc. 16 at 9. But because "surgical abortion" is the term almost universally used throughout the medical literature and case law—indeed, Plaintiff Dr. Burns' clinic is the "Abortion Surgery Center," Doc. 16-5 at ¶ 4—Defendants will continue to use the term "surgical abortion." *See* Ex. 4, Valley Decl., ¶ 6.[30]

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[29] Marilynn Marchione, *Cancer, Heart Surgeries Delayed as Coronavirus Alters Care*, Associated Press (Mar. 18, 2020), https://apnews.com/c161afff751e36d0cac4b59760288eb5.

[30] *See also, e.g.*, Doc. 16-4 at 6 n.4 (citing study on "surgical abortion"); *Abortion Information By State*, PLANNED PARENTHOOD GREAT PLAINS COMPREHENSIVE HEALTH, https://www.plannedparenthood.org/planned-parenthood-comprehensive-health-great-plains/abortion-information (accessed April 1, 2020) ("Surgical abortion is offered at Planned Parenthood Great Plains Comprehensive Health Center in Overland Park, Kansas and Oklahoma City, Oklahoma."); *Fees*, ABORTION SURGERY CENTER, http://www.abortionsurgerycenter.com/fees (accessed April 1, 2020) (listing a charge of $590 for "Surgical Abortion"); *Patient*

Plaintiffs' word games aside, for surgical abortions in the first trimester, doctors most often utilize a suction or vacuum aspiration procedure to remove the fetus. *Gonzales*, 550 U.S. at 134. The risks include infection, hemorrhage, uterine perforation, and incomplete abortion resulting in retained portions of pregnancy. Ex. 4, Valley Decl., ¶ 3.

In the second trimester, most surgical abortions involve the dilation and evacuation (D&E) procedure (which once included the now-banned partial birth abortion). *Gonzalez*, 550 U.S. at 135. During a D&E, the abortionist first dilates the cervix using drugs or instruments inserted into the cervix and, after sufficient dilation, places the woman under general anesthesia or conscious sedation. *Id.* Often guided by ultrasound, the doctor will then use surgical instruments such as forceps to grab the fetus and remove it from the uterus. *Id.* In a D&E, "the abortionist [uses] instruments to grasp a portion (such as a foot or hand) of a developed and living fetus and drag the grasped portion out of the uterus into the vagina." *Stenberg v. Carhart*, 530 U.S. 914, 958 (2000) (Kennedy, J., dissenting). He then "uses the traction created by the opening between the uterus and vagina to dismember the fetus, tearing the grasped portion away from the remainder of the body." *Id.* As a result, "[t]he fetus, in many cases, dies just as a human adult or child would: It bleeds to death as it is torn limb from limb." *Id.* at 958-59. Afterwards, "the abortionist is left with 'a tray full of pieces.'" *Id.*

This entire procedure necessarily must involve close interpersonal contact and, especially during the spread of a highly-contagious virus, *should* require the use of PPE. Ex. 6, Marier Decl. ¶¶ 9-13; Ex. 3, Haney Decl. ¶ 10. Moreover, risks to a woman from a D&E

Care Services: Abortion, TRUST WOMEN OKLAHOMA CITY, https://trustwomen.org/clinics/oklahoma-city/patient-care-services/abortion (accessed April 1, 2020) ("Surgical abortion are performed in the clinic").

include hemorrhage, infection, cervical laceration, uterine perforation, and death. Ex. 4, Valley Decl. ¶ 4. For several of these risks, the complication rate is either unknown or wide-ranging.[31] So in addition to decreasing social distancing and increasing use of PPE, surgical abortions may also increase the use of hospital services.

Medication abortion, while perhaps involving less need for close contact, actually exposes women to a greater risk of serious complications than surgical abortions at the same gestational age, thus potentially requiring the use of more hospital resources. *See* Ex. 7, Harrison Decl., ¶¶ 15-18.[32] The F.D.A. label for medication abortion warns that "[a]bout 85% of patients report at least one adverse reaction following administration of MIFEPREX and misoprostol, and many can be expected to report more than one such reaction."[33] These reactions frequently include fever and vomiting, and can also include hemorrhage, infections, and pelvic inflammatory disease—not just minor side effects.[34] The FDA also warns of "[s]erious and sometimes fatal infections and bleeding" after medication abortion, as displayed prominently on FDA's "black box" warning.[35] Accordingly, it has instituted a Risk Evaluation

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[31] ACOG Practice Bulletin Number 135: Second Trimester Abortion, Obstetrics & Gynecology 121(6), at 1398 (2013) (complication rate for infection after D&E "has not been clearly defined in all studies" and reportedly ranges from 0.1 - 4%).

[32] The referenced exhibit attached to this motion was originally filed in *South Wind Women's Center v. Hunter*, No. CV-2019-2506 (Okla. Cnty.). Because of the timing and practical constraints during the public health emergency, Defendants were not able to secure a new declaration styled for this case, but orally confirmed with Dr. Harrison that she stands by her previous declaration and desires that the same be filed as an exhibit in this case.

[33] FDA Mifeprex Label at 7, https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf .

[34] *Id.* at 7-8.

[35] *Id.* at 1.

and Mitigation Strategy (REMS) because of "the risk of serious complications."[36] "[O]nly a few medications" with "serious safety concerns" require a REMS, according to the FDA.[37]

Studies shows that the risk of the risk of incomplete abortion (requiring surgical follow-up) is over 6% and the risk of hospitalization between 3% and 5%. Ex. 7, Harrison Decl. ¶¶ 16-17, 19, 26. Plaintiffs cite one study, which found the "major" complication rate to be 0.31%. Doc. 16-4, ¶ 20. But that study defined "major" to exclude certain ER visits, hemorrhaging, and seizures; it also could not determine whether any deaths occurred. Ex. 7, Harrison Decl. ¶ 27. And that study's "total" abortion-related complication rate was 5.2% for medication abortion. *Id.* In Texas alone, at least 210 women are hospitalized after an abortion a year. *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 748 F.3d 583, 595 (5th Cir. 2014). But all this data is likely to be *understating* complications due to widespread inadequacies in reporting: Healthcare providers are not all required to report complications, follow-up is poor, and abortion advocates and providers have at times encouraged women not to report the source of complications, which can often be mistaken for a spontaneous miscarriage. Ex. 7, Harrison Decl. ¶¶ 13-14, 41-47.[38] While Plaintiffs claim they only rarely "transfer" abortion patients to the hospital, Doc. 16 at 13, that choice of wording is deliberate: because abortion

[36] *Id.* at 1-2; FDA Warning Letter: Rablon (March 8, 2019) at 2, https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/warning-letters/rablon-1111111-03082019.

[37] FDA REMS at 1, https://www.fda.gov/drugs/drug-safety-and-availability/risk-evaluation-and-mitigation-strategies-rems.

[38] *See also* Aff. of Sue Thayer, Exhibit 5 to Response in Opposition to Motion for a Temporary Injunction, *South Wind Women's Center v. Hunter*, No. CV-2019-2506 (Okla. Cnty. Jan. 14, 2020) (former Planned Parenthood clinic manager who testified that her superiors instructed employees to "tell those reporting to the ER to just say they were having a miscarriage").

clinics are not required to have hospital admitting privileges, *see Burns v. Cline*, 387 P.3d 348, 352-53 (Okla. 2016), and patients are told by Plaintiffs to complete the medication abortion after they *leave* the clinic, Doc. 16-4 at ¶ 14, patients with serious complications go to the hospital directly, which is not a "transfer" from the abortion clinic, *Whole Women's Health v. Hellerstedt*, 136 S. Ct. 2292, 2311 (2016); *see also* Ex. 8, Sanders Decl. ¶ 4.

In sum, elective abortion is no different from most other elective procedures: it decreases social distancing, it requires the use of PPE, and it increases the short-term risk of hospitalization and the use of other medical resources. When the whole society is making their small and large contributions to fight the pandemic—the cumulative effect of which may save thousands of lives—Plaintiffs offer no reason why elective abortion should not be treated just like everything else and subject to short-term delay.

ARGUMENT

A plaintiff seeking a preliminary injunction must show (1) the movant is substantially likely to succeed on the merits, (2) the movant is likely to suffer irreparable injury if the court denies the injunction, (3) that the threatened injury, absent the injunction, outweighs the opposing party's injury from the injunction, and (4) that the injunction is not adverse to the public interest. *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). The movant bears the burden of proof on each of the factors. *Heideman v. S. Salt Lake City*, 348 F.3d 1182, 1188-89 (10th Cir. 2003). Harm that is speculative or hypothetical will not suffice; the harm must be both certain and great, not merely serious and substantial. *Dominion Video Satellite, Inc. v. Echostar Satellite Corp.*, 356 F.3d 1256, 1262 (10th Cir. 2004).

Where a movant, as here, seeks injunctive relief "that afford[s] the movant all the relief that it could recover at the conclusion of a full trial on the merits," it seeks a disfavored injunction and must satisfy a heightened standard. *Fish v. Kobach*, 840 F.3d 710, 723 (10th Cir. 2016) (quoting *Awad v. Ziriax*, 670 F.3d 1111, 1132 (10th Cir. 2012)). Under this heightened standard, the movant must make a strong showing under both the likelihood of success on the merits and the balance of equities before an injunction can issue. *See id.* Moreover, Courts must be especially reluctant to exercise this equitable relief in time of crisis: "The courts' peculiar function is to say what the law is, not to second-guess democratic determinations of the public interest." *Heideman*, 348 F.3d at 1191.

I. PLAINTIFFS ARE NOT LIKELY TO PREVAIL ON THE MERITS

To start, Plaintiffs are not likely to succeed on the merits because they lack standing to assert their patients' alleged injuries. "[A] party 'generally must assert his own legal rights and interests, and cannot rest his claim to relief on the legal rights or interests of third parties.'" *Kowalski v. Tesmer*, 543 U.S. 125, 129 (2004) (quoting *Warth v. Seldin*, 422 U.S. 490, 499 (1975)). An exception to this rule applies where a party can prove two additional criteria: (1) "the party asserting the right has a 'close' relationship with the person who possesses the right," and (2) "there is a 'hindrance' to the possessor's ability to protect his own interests." *Id.* at 130.

Neither criteria is met here. Instead of a close relationship, Plaintiffs have a conflict of interest with their patients because their economic interests favor continuing business as usual while patient safety interests favor decreasing the spread of COVID-19. There is also no hindrance to patients bringing their own suit. *See, e.g.*, *Doe v. Parson*, 368 F. Supp. 3d 1345, 1347 (E.D. Mo. 2019); *cf. Robinson v. Marshall*, No. 2:19cv365, Doc. No. 73, Ex. 3 (M.D. Al. Mar. 30,

2020) (abortion patient in Alabama claiming own rights in COVID-19 litigation). Plaintiffs have not even attempted to demonstrate that any hindrance exists here. Thus, Plaintiffs have failed to prove the criteria necessary for them to assert third party standing.[39]

Even if Plaintiffs have standing, their constitutional claim is unlikely to succeed on the merits. The State's plan to "flatten the curve" is within its legitimate police power.

A. The State's police powers extend to protecting public health, especially during times of emergency, and abortion may be regulated to protect public health.

This case centers on whether the State has the authority to take actions to protect the public health, including the regulation of abortion. It thus comes at the intersection of two lines of precedent: the State's police powers to protect the public health, especially during an emergency, and the state's regulation of access to abortion.

1. The State's police power to protect public health, including during emergencies

Under the Constitution, the State's retain the well-established police power to protect public health, safety, and welfare. U.S. CONST. amend. X; *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11, 25 (1905). This empowers states to enact laws putting restrictions on *individual* activities, including activities that generally receive protection by the Constitution, in order to protect the rights of *everyone else* in society. As relevant here, through the police power, "a community has the right to protect itself against an epidemic of disease which threatens the safety of its members." *Id.*; *see also Banzhaf v. F.C.C.*, 405 F.2d 1082, 1097 (D.C. Cir. 1968) ("The power to protect the public health lies at the heart of the states' police power" and "[i]t has sustained many of the most drastic exercises of that power.").

[39] The Supreme Court is currently considering whether abortion providers can assert third-party standing on behalf of patients. *See Russo v. June Medical Services LLC*, No. 18-1460 (U.S.).

For example, courts have long "distinctly recognized the authority of a state to enact quarantine laws and health laws of every description." *Jacobson*, 197 U.S. at 25; *see also Compagnie Francaise de Navigation a Vapeur v. Bd. of Health of State of La.*, 186 U.S. 380 (1902) (upholding quarantine); *Hickox v. Christie*, 205 F. Supp. 3d 579, 585 (D.N.J. 2016) (upholding quarantine of nurse treating Ebola patients). Quarantines, of course, restrict the right of movement, which is the core right of "liberty" protected by the Fourteenth Amendment. *See Jacobson*, 197 U.S. at 29. But quarantines limit liberty to protect the interests of all other citizens in life and health.

Similarly, to protect public health, states can also restrict interstate and foreign commerce, even though normally forbidden under Article I of the Constitution. *See Compagnie Francaise*, 186 U.S. at 387; *Rasmussen v. State of Id.*, 181 U.S. 198 (1901). As the Tenth Circuit recently held, the police power is also not restricted by the constitutional prohibition on uncompensated taking of property in order to protect the public health and safety. *Lech v. Jackson*, 791 Fed. App'x 711, 717 (10th Cir. 2019), *cert. pet. filed* No. 19-1123 (U.S.); *see also Sentell v. New Orleans & C.R. Co.*, 166 U.S. 698 (1897).

Even the paramount interests of the First Amendment are subject to public health regulation. *See Banzhaf*, 405 F.2d at 1097-1103; *cf. also Benson v. Walker*, 274 F. 622 (4th Cir. 1921) (upholding prohibition on certain large assemblies during Spanish flu crisis). And, as here, state regulation of public health can also overcome claims of violation of the Fourteenth Amendment and the rights regarding bodily integrity and medical treatment. *Jacobson*, 197 U.S. at 14, 26; *Phillips v. City of N.Y.*, 775 F.3d 538 (2d Cir. 2015). Thus, when in Denver "the incidence of venereal disease had reached virtually epidemic proportions," the Tenth Circuit upheld against a Fourteenth Amendment challenge a law that forced detention or treatment

of suspected carriers "as a valid exercise of the police power designed to protect the public health." *Reynolds v. McNichols*, 488 F.2d 1378, 1381-83 (10th Cir. 1973).

This power only increases during times of emergency and crisis, and can tip the balance in analyzing constitutional rights that, in other times, would not survive judicial scrutiny. "[T]he rights of the individual in respect of his liberty may at times, under the pressure of great dangers, be subjected to such restraint, to be enforced by reasonable regulations, as the safety of the general public may demand." *Jacobson*, 197 U.S. at 29; *see also Sentell v. New Orleans & C.R. Co.*, 166 U.S. 698, 704-05 (1897) ("it is clearly within the power of the state to order [property] destruction in times of epidemic" and whenever such property "become[s] infected and dangerous to the public health"). The Supreme Court "ha[s] long recognized," for example, "that in times of imminent peril—such as when fire threatened a whole community—the sovereign could, with immunity, destroy the property of a few that the property of many and the lives of many more could be saved." *United States v. Caltex*, 344 U.S. 149, 154 (1952) (destruction of property in retreat from Japanese forces after Pearl Harbor).[40] "Exigencies of the kind do arise in time of war or impending public danger, but it is the emergency, as was said by a great magistrate, that gives the right . . . ." *Caltex*, 344 U.S. at 153 (quoting *United States v. Russell*, 80 U.S. 623, 628 (1871)).

As has been said often, no right is absolute. *Jacobson*, 197 U.S. at 26; *United States v. Huitron-Guizar*, 678 F.3d 1164, 1166 (10th Cir. 2012); *Furnace v. Oklahoma Corp. Comm'n*, 51 F.3d 932, 936 (10th Cir. 1995).

[40] *See also Juragua Iron Co. v. U.S.*, 212 U.S. 297 (1909) (destruction of property to slow spread of yellow fever); *Lech v. Jackson*, 2018 WL 10215862 at *7 (D. Colo. Jan. 8, 2018), *aff'd*, 791 Fed. Appx. 711 (10th Cir. 2019).

The situation now is on par with the many cases just cited where the State's police power has been upheld in the face of constitutional challenges asserting individual rights. COVID-19 is "prevalent to some extent in the [State], and the disease [is] increasing." *Jacobson*, 197 U.S. at 27; *see also supra* pp. 3-6. It has forced this State, and all other states, to restrict many liberties. Few rights are more sacred than those in the First Amendment, yet gatherings greater than 10 people are prohibited by the executive order challenged today.[41] In Ohio, elections have been postponed and, despite the right to vote, that action has been upheld.[42] In Oklahoma, too, the State has delayed other processes at the heart of our democracy, like signature gathering for initiative petitions. *See In re: State Question No. 805*, No. 118,719 (Okla. Mar. 18, 2020). Even this Court has had to shift course in the face of this crisis, despite speedy trial rights of criminal defendants. *See* General Order 20-8 (W.D. Okla. Mar. 17, 2020).

The virus is not unlike an enemy advancing at war, and "[w]hatever would embarrass or impede the advance of the enemy, … or would cripple and defeat him, as destroying his means of subsistence" is the "imperative duty" of our leaders, that "overrides all considerations of private loss," which sadly must "be borne by the sufferers alone." *Caltex*, 344 U.S. at 153-55 (quoting *United States v. Pacific R. Co.*, 120 U.S. 227, 234 (1887)). Here, the "means of subsistence" we must deprive our viral enemy in the short term to minimize the loss of life is (1) close interpersonal contact, (2) depletion of medical PPE, and (3) activities that will increase

[41] Fourth Amended Executive Order 2020-07, Mar. 24, 2020, https://www.sos.ok.gov/documents/executive/1919.pdf.

[42] J. Edward Moreno, *Ohio Supreme Court denied challenge to state primary delay*, THE HILL (Mar. 17, 2020), https://thehill.com/homenews/state-watch/487983-ohio-supreme-court-denies-challenge-to-state-primary-delay.

the use of hospital beds, staff, and other resources. Achieving these ends by reasonable means is within the State's well-recognized constitutional police power.

2. Abortion, too, may be regulated to protect the public health

Plaintiffs believe they are exempt from all this. They effectively claim that access to abortion is the only act under the Constitution that cannot be temporarily delayed or curtailed to protect the public health during a pandemic, even as other elective procedures—and protected activities (assembly, commerce, travel, movement, etc.)—are postponed across the State. But "the law need not give abortion doctors unfettered choice in the course of their medical practice, nor should it elevate their status above other physicians in the medical community." *Gonzales*, 550 U.S. at 163.

Even when no emergency exists, under *Planned Parenthood v. Casey* the state may regulate abortion to protect the public health. 505 U.S. 833, 852, 882 (1992) (24-hour reflection period valid abortion regulation because, *inter alia*, promotes mental health). Thus, for example, the Supreme Court has repeatedly upheld state laws that require a physician to perform an abortion "to ensure the safety of the abortion procedure." *Mazurek v. Armstrong*, 520 U.S. 968, 974-75 (*per curiam*); *see also Gonzalez*, 550 U.S. at 163-64; *Casey*, 505 U.S. at 884-85; *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 447 (1983), *overruled on other grounds*, *Casey*, 505 U.S. at 882; *Roe v. Wade*, 410 U.S. 113, 165 (1973). The "State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." *Roe*, 410 U.S. at 150.

Health regulations are permissible even when they reduce abortion availability or (like here) cause delay. *Casey*, 505 U.S. at 866. As *Casey* held, "not every law which makes a right more

difficult to exercise is, *ipso facto*, an infringement of that right," and "the States are granted substantial flexibility" in their regulations. *Id.* at 873. Rather, under *Casey*'s "undue burden" standard, a health regulation may burden abortion access—such as delaying or reducing the availability of abortions—so long as that "burden" is not "undue." *Id.* at 874. The public health interests, in other words, must justify imposing a burden—an analysis not dissimilar from the police power precedent described above. The benefits the law confers are weighed against the burden the law imposes on abortion access. *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309, 2313 (2016) (reaffirming *Casey* standard).

Contrary to Plaintiffs' claim (Doc. 16 at 7), *Casey* did not categorically prohibit states from limiting pre-viability abortions; it only addressed viability with respect to how to balance "the State's profound interest ***in potential life***" against "the woman's constitutionally protected liberty." *Casey*, 505 U.S. at 876-77 (emphasis added). That is, the viability line is only relevant when the State's sole justification is protecting fetal life: "[V]iability marks the earliest point at which the State's interest in fetal life is constitutionally adequate to justify a legislative ban on nontherapeutic abortions." I*d.* at 860. In fact, "*Casey* rejected . . . the interpretation of *Roe* that considered all previability regulations of abortion unwarranted." *Gonzales v. Carhart*, 550 U.S. 124, 146 (2007).[43] Well before viability, Oklahoma "has legitimate interests ***from the outset of the pregnancy*** in protecting the health of the woman"—and the health of the rest of

[43] The Tenth Circuit also does not have a categorical rule against regulating pre-viability abortions. In the case cited by Plaintiffs, the court held that a state asserting its interest in potential life cannot categorically define when viability starts. *Jane L. v. Bangerter*, 102 F.3d 1112, 1116-17 (10th Cir. 1996). The Tenth Circuit held that a post-20 week abortion prohibition was invalid because some fetuses would be nonviable even after 20 weeks. *See id.* at 1117-18. Thus, the opinion only addressed the state's interest in potential life, similar to *Casey*, and expressed no view on other possible state interests.

society. *Casey*, 505 U.S. at 846 (emphasis added). Here, the State's primary interest is in protecting the public health—for *all* persons—by preventing the rapid spread of a pandemic and the collapse of our healthcare system. And again, the State's authority to protect the public health only increases during an emergency.

3. The Court must uphold the State's policy choice to protect public health, including by delaying elective abortions, so long as its judgment is not manifestly unreasonable or arbitrary

Of course, use of extraordinary emergency power cannot extend past the time of emergency, and the police power cannot be exercised in a manner that is "unreasonable or arbitrary"—but a challenge to the police power must prove "the means prescribed by the state … has no real or substantial relation to the protection of the public health and the public safety." *Jacobson*, 197 U.S. at 27, 31. Ultimately, however, the authority to decide "in the first instance" among many possible *reasonable* choices that which is best to protect the public health lies "primarily … in [the] wisdom" of the people's representatives, and courts should be careful not to "usurp the functions of another branch of government." *Jacobson*, 197 U.S. at 28, 38.[44]

Regulation of abortion is subject to the same deference to the People's choices: "the States are granted substantial flexibility," *Casey*, 505 U.S. at 872, and "[c]onsiderations of marginal safety, including the balance of risks, are within the legislative competence when the regulation

[44] *See also Benson*, 274 F. at 624 ("It is not for the courts … to substitute their judgment for that of the legislative or municipal authority …, unless those acting have plainly and manifestly exceeded their power and authority to the prejudice of those affected," a rule that "is strikingly true in considering rules and regulations coming clearly within the domain and discretion of public health authorities."); *Hickox v. Christie*, 205 F. Supp. 3d 579, 584-85, 593 (D.N.J. 2016) ("The State is entitled to some latitude, however, in its prophylactic efforts to contain what is, at present, an incurable and often fatal disease," and restriction permissible if "State could reasonably have thought" it necessary); *id.* at 590 (length of quarantine "is a judgment call" and "there is no bright-line statutory or constitutional rule").

is rational and in pursuit of legitimate ends," *Gonzalez*, 550 U.S. at 166-67; *see also Hellerstedt*, 136 S. Ct. at 2309 (reaffirming *Gonzalez*'s "deferential" review of legislative factfinding).

Plaintiffs take the opposite view, saying the government has no role in such matters, but instead individual businesses, physicians, and patients "should be the ones deciding" which medical services "need to be performed, and which ones can wait." Doc 16 at 29. But that position, as shown, is contrary to all precedent. Weighing the public health costs and benefits "is a determination for the legislature, not the individual objectors." *Phillips v. City of New York*, 775 F.3d 538, 542 (2d Cir. 2015). Respecting our elected leaders' ability to coordinate society's response to a public health crisis is vital. After all, "public health officials 'deal in a terrible context [where] the consequences of mistaken indulgence can be irretrievably tragic'" and a "better-safe-than-sorry determination [is] therefore entitled to deference, absent a 'reliable showing of error.'" *Hickox*, 205 F.Supp.3d at 592 (quoting *U.S. ex rel. Siegel v. Shinnick*, 219 F.Supp. 789, 791 (E.D.N.Y. 1963)); *Caltex*, 344 U.S. at 155 n.7 (recounting how authorities failed to act for fear of lawyers in London, and as a result "half that great city was burnt").

Overturning society's public health response, as Plaintiffs' seek, must only occur in an "extreme situation where a judgment call becomes a clear and unmistakable error." *Hickox*, 205 F.Supp.3d at 594 (citing *Reynolds*, 488 F.2d at 1383)). But ultimately, when there are competing interests, "the state [is] under the necessity of making a choice" and "[w]hen forced to such a choice the state does not exceed its constitutional powers by deciding upon" that "which, in the judgment of the legislature, is of greater value to the public." *Miller v. Schoene*, 276 U.S. 272, 279 (1928); *see also id.* at 280 (where "the choice is unavoidable, we cannot say

that its exercise, controlled by considerations of social policy which are not unreasonable, involves any denial of due process").

Admittedly, the Supreme Court has never addressed the intersection of the abortion right in *Casey* and the precedent on the State's police power to address pandemics. But neither line of precedent can be ignored. *Casey*'s undue burden standard is less rigorous, say, than the First Amendment's strict scrutiny standard, *see, e.g.*, *Planned Parenthood Arizona, Inc. v. Humble*, 753 F.3d 905, 911 (9th Cir. 2014), but even the rights of the First Amendment are subject to the state's regulation of public health, *see supra* p. 16. Merging the two lines of cases, the sum total is this: individual liberties, including access to abortion, may be limited by the people's compelling interest in preserving public health—and thousands of lives—during a pandemic, but such limits must not be arbitrary or beyond the bounds of reason. When a difficult judgment call is to be made, deference must be afforded to the reasonable choice of our elected representatives, rather than allow individual objectors to dictate the public health response.

B. The State is not unreasonable in determining that a delay in elective procedures, including elective abortion, will assist in flattening the curve and thereby promoting the most compelling interests in public health.

The People's interest in minimizing the toll on human life from the COVID-19 is of the highest order. There can be no doubt that the State acts within its legitimate police power to protect public health when in implements a variety of measures all designed to "flatten the curve" and ensure that our healthcare system can manage the virus's peak impact in the near future. These measures must be *cumulative* and include business closures, prohibition on large gatherings, "safer at home" policies, and, as relevant here, postponement of elective procedures. All are burdened by this policy, but the hope is that all will benefit. Any burden

on abortion access is not "undue"—in fact, it is instead justified by the most compelling governmental interests.

Viral spread. The postponement of elective procedures will promote social distancing because it will discourage patients from interacting with other patients, staff, and physicians. Ex. 3, Haney Decl., ¶¶ 5, 10. This includes abortion clinics where medical staff must necessarily be in close physical proximity to the patient to perform the ultrasound and/or surgical abortion. *See supra* p. 10. If abortion procedures are not delayed, all of these additional risks of potential new infections will compound hundreds or thousands of times. Doc. 1, Complaint ¶ 41 (4,500 abortions a year in Oklahoma); Doc. 16-5, Burns Decl., ¶ 12 (25 to 40 abortions per week); Doc. 16-6, Burkhart Decl., ¶ 15 (cancelled 164 abortion appointments); Doc. 16-7, Hill Decl., ¶ 9 (322 abortions so far in 2020 at Planned Parenthood alone). This is doubled with medication abortion, which requires a follow-up to ensure the abortion is completed.[45]

Plaintiffs claim that they have taken precautionary measures to limit the spread, but even if partially effective, the risk to society is still increased by all these interpersonal interactions. In any event, Defendants are "not required … to take it on faith that [they will be] 100% compliant, or the measures 100% effective." *Hickox*, 205 F.Supp.3d at 585, 593. *Every* business or activity—or clinic that performs elective procedures—can claim they are taking precautionary measures so they shouldn't be regulated; by that logic, the State's attempt to "flatten the curve" would utterly collapse.

[45] *See* Mifeprex (mifepristone) tablets Label, § 2.3, U.S. FOOD AND DRUG ADMIN., Mar. 2016, https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf.

And as it is, Plaintiffs' protective measures are wholly inadequate. For example, Plaintiffs are forcing their symptomatic patients to postpone their abortion (Doc. 16 at 12-13)—the exact act they complain of—but as many as 25% of COVID-19 cases are asymptomatic, and even for those who experience symptoms, they may not set in for 48 hours and they may continue to spread the virus 15 days after symptoms onset.[46] Plaintiffs' screening thus likely does little to prevent other patients and their staff—all who will then interact with yet more people—from spreading the virus. *See* Ex. 1, Loughridge Decl., ¶ 9; Ex. 3, Haney Decl. ¶ 10; Ex. 6, Marier Decl. ¶¶ 6-8.

Plaintiffs also speculate that postponing elective abortions would incentivize out-of-state travel. Doc 16 at 17, 24-25. But again, this speculation could be made by *every* business and for *every* elective procedure. Moreover, allowing elective abortions to continue will cause travel from all parts of the State to the Oklahoma City metro and, as Plaintiffs admit, out-of-state persons will travel *to Oklahoma* to seek abortions. Doc. 16-5, Burns Decl. at ¶ 34; Doc. 16-6, Burkhart Decl. at ¶ 38. The Fifth Circuit, as of this writing, has allowed Texas's elective procedure delay to go into effect as applied to abortions,[47] so failure to delay elective abortions in Oklahoma will likely cause more people from Texas—which has more positive cases of COVID-19—to travel to Oklahoma (in addition to travel from Kansas, Missouri, Arkansas,

[46] *See* Coronavirus Disease 2019 (COVID-19), Healthcare Professionals: Frequently Asked Questions and Answers, Centers for Disease Control and Prevention (last updated March 30, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html; Sam Whitehead, *CDC Director on models for the months to come*, NPR (March 31, 2020), https://www.npr.org/sections/health-shots/2020/03/31/824155179/cdc-director-on-models-for-the-months-to-come-this-virus-is-going-to-be-with-us.

[47] *See In re Gregg Abbott, et al.*, No. 20-50264 (5th Cir. Mar. 31, 2020).

etc.). In fact, permitting elective abortions to go forward without postponement will mean Plaintiffs will fly in doctors from other states to perform abortions. Doc. 16-4, Schivone Decl. at ¶¶ 4, 10. None of this is required by the Constitution when the State is fighting a pandemic.

Use of PPE. Proper medical practice during this pandemic requires extensive use of PPE. Ex. 6, Marier Decl, ¶¶ 9-13; Ex. 3, Haney Decl. ¶¶ 7, 10; Ex. 2, Mareshie Decl. ¶¶ 4-7; Ex. 8, Sanders Decl. ¶ 5. Plaintiffs do not contest that elective abortions diminishes the statewide supply of PPE. *See* Doc. 16 at 13, 15; *see also* Ex. 4, Valley Decl., ¶ 9. Plaintiffs also admit they "have an ***important*** role to play in minimizing spread of the virus and preserving medical supplies." Doc. 16 at 12 (emphasis added). They just refuse to play it.[48]

Plaintiffs minimize their impact on the overall supply of PPE, but that misses the point: all elective procedures use only a small fraction of the state's supply of PPE, but *cumulatively* they represent an estimated 25% of the State's supply. Ex. 1, Loughridge Decl., ¶ 14. However much Plaintiffs may downplay the public harm that would be caused if they alone were allowed to operate, "[i]f such be the privilege of a minority, then a like privilege would belong to each individual of the community," destroying entirely the State's ability to protect the public health. *Jacobsen*, 197 U.S. at 37-38; *see also* Ex. 3, Haney Decl. ¶ 12; Ex. 2, Mareshie Decl. ¶¶ 7-8.

Moreover, Plaintiffs' decision to forgo using PPE, or to refuse to use the most effective PPE, is extremely troublesome. Doc. 16 at 14-15. For some procedures, Planned Parenthood uses no PPE at all, *id.* as 14 (citing Doc. 16-7, Hill Decl. ¶ 9), even though they should be in

[48] In fact, in other states where abortion clinics have continued to operate, Planned Parenthood is asking for *donations* of PPE for abortions, further diminishing the supply to hospitals and others. *See Donations Needed,* PLANNED PARENTHOOD KEYSTONE*,* https://www.facebook.com/PPKeystone/posts/10156930440922665.

close contact with the patient to perform an ultrasound that confirms pregnancy and to conduct a physical examination for abortion contraindications. Plaintiffs' reduced use of PPE only worsens the *first* problem: it increases the likelihood the virus will spread, a "reckless" practice. Ex. 4, Valley Decl. ¶ 10; Ex. 3, Haney Decl. ¶ 10; Ex. 6, Marier Decl. ¶¶ 12-14. The better option is simply to delay procedures until after the peak impact on our healthcare system has passed. Ex. 1, Loughridge Decl., ¶ 9, 12.

Use of hospital resources. Abortion increases the short-term risk that a pregnant woman will need hospitalization. *See supra* pp. 10-13; *see also* Ex. 8, Sanders Decl., ¶ 8. Plaintiffs point out that carrying a pregnancy to term (or having a later abortion) will increase the need for hospital treatment "in the long run." Doc. at 16-17, 24. But that still benefits public health under the "flatten the curve" strategy: use of hospital resources *now*, while the pandemic is surging, will have a far greater cost on human life than use of hospital resources several months from now, when our healthcare system has greater capacity and lower demand. *See* Ex. 4, Valley Decl., ¶ 11.[49]

Nor is it the case that continued pregnancy requires greater immediate use of healthcare resources than abortion. Doc. 16 at 16, 24. In the short term, most prenatal visits can be postponed or performed by telemedicine—as is already happening. Ex. 8, Sanders Decl., ¶ 6; Ex. 4, Valley Decl. ¶¶ 7-11.[50]

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[49] Plaintiffs note that the pandemic may last 12-18 months. While that may be the timeline for broad public vaccination, what is relevant here is not the total length of the pandemic, but the time viral infections surge to the point that our healthcare system is severely strained.

[50] Plaintiffs claim that the risk of dying in childbirth is 14 times higher than from having an abortion, but "this statement is unsupported by the literature and there is no credible scientific basis to support it." Byron Calhoun, *The Maternal Mortality Myth in the Context of Legalized*

Burden on abortion. Plaintiffs list the many ways that a delay in elective abortion procedures will burden their patients. But everyone in Oklahoma is being burdened by the pandemic and our collective public health response to it, some more than others. "The fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it." *Casey,* 505 U.S at 874. People across the State are foregoing their livelihoods, their religious practices, and their political activities. They are also postponing elective procedures they many may feel more important than abortion such as cataract surgery, chronic pain relief, cancer surgery, and pacemaker installation. *Supra* 8-9; Ex. 8, Sanders Decl. ¶ 9.

Plaintiffs have not shown that these necessary decisions are any less risky or less burdensome than postponing an elective abortion. Plaintiffs seek to be the only members of society exempt from the rules society has agreed upon to flatten the curve. But the law is clear: Plaintiffs are not free from "restraints to which every person is necessarily subject for the common good" to become "a law unto himself," abusing individual rights "regardless of the injury that may be done to others." *Jacobson*, 197 U.S. at 26-27.[51]

Abortion, Linacre Q. 2013 Aug. 80(3): 264-276, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6027002/.

[51] Plaintiffs speculate about harms COVID-19 might cause to women who remain pregnant, but admit "very little is known about COVID-19, particularly as it relates to its effects on pregnant women and infants." *See* Doc. 16 at 8, 11-12, 22. Such speculation cannot justify injunctive relief. Similarly, we also know little about whether having an abortion increases the risks posed by COVID-19 in the timeframe after an abortion—risks that may be greater than those who continue their pregnancy.

To be sure, these are weighty concerns. But it is the "duty" of the people's elected representatives "to keep in view the welfare, comfort, and safety of the many, and not permit the interests of the many to be subordinated to the wishes or convenience of the few." *Jacobson*, 197 U.S. at 29. Some, like Plaintiffs, are criticizing our elected leaders for doing too much, others are saying they are doing too little. Hindsight may judge, ultimately, which is the case. But difficult decisions must be made today, and it is the prerogative of our democratic branches of Government to make them within the bounds of reason. *See supra* pp. 21-23. Precedent is clear that plaintiffs should not force courts into a place where they are managing the pandemic response—deciding which measures are wise and which are not—instead of allowing the executive and legislative branches to make those calls. *Id.*[52]

For all these reasons, the State's decision to postpone elective procedures, including elective abortions, is a reasonable public health measure within the State's police power, not an "undue" burden on abortion.[53] Plaintiffs tacitly admit this in deeds, even if not in words:

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[52] Plaintiffs point to other States that are allowing elective abortions, like Washington, Illinois, Minnesota, Massachusetts, and New Jersey. Doc. 16 at 1. But that is the point of our federal system: each State must make the policy choice it deems best. Oklahoma cannot be forced into making the same policy choices of States that have *more* cases of COVID-19.

[53] Defendants point to three court decisions on this matter, but they offer little support to Plaintiffs' position. The district court in Ohio only granted abortion clinics partial relief, specifying that "Plaintiff healthcare providers are to determine if a surgical abortion procedure can be safely postponed" and can only perform an abortion under the executive order if "a healthcare provider determines, on a case-by-case basis, that the surgical procedure is medically indicated and cannot be delayed." Doc. 16-2, at 7-8. The district court in Alabama granted an order before any response from the state defendants and, as a result, did not address the state's police powers during a crisis. *See* Doc. 16-3. The district court in Texas also did not address the state's police powers and had its decision stayed by the Fifth Circuit. *See In re Gregg Abbott, et al.*, No. 20-50264 (5th Cir. Mar. 31, 2020). In any event, this Court must reach its own decision and, if anything, should follow the lead of the Fifth Circuit.

they turn away symptomatic patients and ask them to do the same thing the State is asking—postpone your abortion. Doc. 16, Doc. 16 at 12-13. They are also purposefully curtailing access to abortions in their clinic by reducing hours and appointments to "decrease patient volume." Doc. 16-7, Hill Decl. ¶¶ 13-14. Why? Because it is eminently reasonable, if not vital, to delay these procedures. Given the vast numbers of infected persons who are asymptomatic or not-yet-symptomatic, the State can reasonably ask *all* to delay their elective abortions, not just the symptomatic ones or those Plaintiffs arbitrarily exclude by cutting back appointments. Plaintiffs' own practices demonstrate they are not likely to succeed on the merits.

II. THE BALANCE OF EQUITIES FAVORS ALLOWING THE STATE TO CONTINUE TO FLATTEN THE CURVE.

The party seeking injunctive relief must demonstrate that the balance of equities favor it when the court weighs "the irreparable harms [the court has] identified against the harm to defendants if the preliminary injunction is granted." *Fish*, 840 F.3d at 754 (citation omitted). Even irreparable harms to plaintiffs do not warrant injunctive relief when weighed against strong state interests. *See Winter*, 555 U.S. at 26. The harm to defendants is weighed in light of whether the law at issue "address[es] any immediate problem" such that delayed implementation would "cause material harm." *Awad*, 670 F.3d at 1132. Thus while Plaintiffs urge the Court to "preserve the status quo," Doc. 16 at 3, the current status quo is a rapidly spreading virus that endangers hundreds of thousands of lives. The Court should not be anxious to preserve it. Given the pandemic and the need to flatten the curve, equity and the interests of all society does not favor Plaintiffs' request.

A. Plaintiffs' alleged irreparable harm does not outweigh the State's interest in preventing a health catastrophe.

Plaintiffs' irreparable harm analysis focuses on their constitutional claim—where they do not have a likelihood of success on the merits. Also, what is at issue in this case is the *delayed exercise* of a constitutional right, not the *ban* of a constitutional right. Delayed exercise of the liberty interest in abortion is permissible even absent a public health crisis. *Casey*, 505 U.S. at 866. Data from one clinic in this state in 2018 showed that patients have to wait on average 9 days for an appointment even when the reflection period law required only 24 hours. *Nova Health Systems v. Hunter*, No. CV-2015-1838, Defs' Exhibits to Mot. for Summary Judgment, Exhibit 18 (Okla. Cnty. July 16, 2018). Plaintiffs themselves are delaying symptomatic patients and restricting appointments. Doc. 16 at 12-13. And according to Plaintiffs, even if an abortion is delayed, the risk of abortion remains low. Doc. 16 at 16. Thus, their alleged constitutional violation fails as irreparable harm because they are wrong on the merits, and the delays in obtaining an elective abortion do not outweigh the public health crisis.

Plaintiffs' remaining allegations about harm fail to be proven with evidence. They allege in passing that "others will be unable to access abortion at all," and they argue that some patients will have to "carry their pregnancies to term." Doc. 1, Compl. ¶ 57; Doc. 16 at 3. With three of the four abortion clinics in the state as plaintiffs, though, they cannot identify a single patient about whom that is true. Data from Plaintiff Planned Parenthood explains this absence: out of 322 abortions at their clinic this year, only 14 were beyond 10 weeks LMP even though the legal limit is 22 weeks LMP. Doc. 16-7 at ¶ 9; Doc. 16 at 10 n.22. Plaintiffs likely have not identified any patients who are unable to access abortion at all because no patient is experiencing that type of harm. To the extent such individual patients exist, the correct

mechanism is an *as-applied* challenge, not the sweeping facial challenge seeking a categorical exemption that Plaintiffs bring here.

Conversely, an injunction would greatly harm Defendants in their management of a public health crisis. The primary public health strategy—to avoid an overwhelmed health care system and subsequent thousands of deaths—is to delay every activity that would increase that risk. This delay implicates multiple fundamental rights, including the right to travel, assembly, speedy trial, and commerce. Unlike the liberty interest in abortion, some of those rights are subject to strict scrutiny. If Oklahoma cannot delay the exercise of certain rights during a public health crisis, it would be unable to enact the public health strategies required to prevent a wave of sickness and death in the state. Oklahoma faces the crippling of its ability to address a public health crisis, while Plaintiffs face only a delay in exercising certain rights. The need to address a crisis outweighs any harm to Plaintiffs.

B. The public interest weighs in favor of allowing a short-term delay of elective procedures, including elective abortion.

The party seeking injunctive relief must also demonstrate that the injunction "is not adverse to the public interest." *Heideman*, 348 F.3d at 1191. "[D]emocratically elected representatives . . . are in a better position than this Court to determine the public interests with respect to questions of social and economic policy." *See id.* Courts assess the immediacy of any harm under this factor because the public's interest in preserving the status quo only applies in cases where "the [defendant] had not identified any immediate threat to the public interest" addressed by the law at issue. *Isbell v. City of Oklahoma City, Okla.*, No. CIV-11-1423-D, 2011 WL 6016906, at *2 (W.D. Okla. Dec. 2, 2011). Here, the status quo is disaster.

The public interest far outstrips the interests of all parties, and it alone requires denying the injunction. As the experience in Italy demonstrates, an ineffective response to COVID-19 leads to thousands of deaths and overwhelmed health care systems that are left to ration care. The public does not face simply delayed care or a loss of crisis management power; it faces the risk of thousands of Oklahomans dying.

Plaintiffs offer nothing to rebut this issue but the suggestion that their use of health care resources alone does not create the lack of resources for the state. Their argument misunderstands the issue: no single elective surgery or minor medical procedure causes the capacity problem, but the *cumulative effect* of all of them causes a capacity problem in addressing COVID-19. *See supra* p. 26. They cannot deny that they contribute to the cumulative usage, and their allegations are really just a means of second-guessing what level of effort is truly necessary to address COVID-19. As the Supreme Court has recognized, a minority of the population cannot enjoin inconveniences to them during a crisis because "the welfare and safety of an entire population" cannot be "subordinated to the notions of a single individual who chooses to remain a part of that population." *Jacobsen*, 197 U.S. at 37–38.

CONCLUSION

For the foregoing reasons, this court should deny Plaintiffs' motion for temporary restraining order or preliminary injunction.

Respectfully Submitted,

s/ *Mithun Mansinghani*

MITHUN MANSINGHANI, OBA 32453
Solicitor General

ZACH WEST, OBA 30768
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Counsel for Defendants

Exhibit 1

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;

LARRY A. BURNS, D.O., on behalf of himself, his staff, and his patients; and

COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, INC., on behalf of itself, its physicians and staff, and its patients,

Plaintiffs,

v.

J. KEVIN STITT, *in his official capacity as* Governor of Oklahoma,

MIKE HUNTER, *in his official capacity as* Attorney General of the State of Oklahoma;

DAVID PRATER, *in his official capacity as* District Attorney for Oklahoma County;

GREG MASHBURN, *in his official capacity as* District Attorney for ClevelandCounty

GARY COX, *in his official capacity as* Oklahoma Commissioner of Health; and

MARK GOWER, *in his official capacity as* Director of the Oklahoma Department of Emergency Management,

Defendants.

Case No: 20-CV-277-G

DECLARATION OF SECRETARY JEROME LOUGHRIDGE

1. I am over 18 years of age, competent to testify in this case, and have personal knowledge of the facts in this declaration.
2. My name is Jerome Loughridge, and I am the Secretary of Health and Mental Health for the State of Oklahoma. As part of this role, I coordinate the state's public health resources and advise the governor on responding to public health crises.
3. Like the rest of the nation, Oklahoma is still facing an increase of COVID-19 cases in the state. The recent spread of COVID-19 has created a crisis for emergency medical care. A further exponential increase is expected in the coming weeks, threatening the ability of emergency medical care in the state to adequately respond to the disease and to other emergency care.
4. Estimates from data throughout the United States indicate that 20.7%-31.4% of COVID-19 cases will require hospitalization, with 4.9%-11.5% requiring intensive care unit admission.
5. Oklahoma's experience is consistent with the data. So far, approximately 25% of confirmed COVID-19 cases in Oklahoma have required hospitalization.
6. In order to prevent the COVID-19 outbreak from overwhelming health care resource, state management of the disease involves several stages.
7. Currently, we are in the mitigation stage, which requires drastic measures to minimize the number of COVID-19 cases in the state at any one time. An important part of this stage is enforcing social distancing and minimizing contact whenever possible. Uniform compliance with these requirements is necessary in the next few weeks to stem the crisis.

8. Because a large percentage of COVID-19 cases require hospitalization, threats from a dramatic increase in COVID-19 cases include reducing the availability of personal protective equipment ("PPE") and overwhelming the capacity of the health care system. Required PPE includes gloves, gowns, face/eye protections, N95 masks, and surgical masks.

9. It is critical that all healthcare personnel have adequate PPE because this disease is asymptomatic. Personnel without adequate PPE could unknowingly transmit the disease themselves to many other healthy individuals before becoming symptomatic.

10. The current crisis has already started creating a shortage of PPE in Oklahoma. In the Oklahoma State Department of Health's initial report on March 22, emergency health care facilities in Oklahoma had an average of only 9.1 days of PPE on hand, with Oklahoma and Tulsa Counties lagging behind at only 3 days of PPE on hand.[1] Extensive efforts over the last week have increased the average to 10.6 days of PPE statewide, but Oklahoma County still only has 5 days of PPE on hand.[2] Some facilities are still reporting 0 days of PPE on hand.

11. The Oklahoma State Department of Health has received many requests for PPE from facilities in the state.

12. Oklahoma is still experiencing a PPE shortage based on our projected needs as the crises worsens. In order to mitigate the shortage, Oklahoma must decrease the use

[1] COVID-19 Report, March 22, 2020, https://coronavirus.health.ok.gov/sites/g/files/gmc786/f/eo_-_covid-19_report_-_3-22-20.pdf.
[2] COVID-19 Report, March 31, 2020, https://coronavirus.health.ok.gov/sites/g/files/gmc786/f/eo_-_covid-19_report_-_3-31-20.pdf.

of PPE throughout the state. Because all healthcare personnel should be using PPE during this crisis due to the asymptomatic nature of the disease, all medical facilities should eliminate other personal interactions between staff and patients to the fullest extent possible. These drastic measures are essential to limit the demand on PPE so that sufficient supplies are available to address COVID-19.

13. Oklahoma must also reduce demand on other hospital resources to prepare for the continued increase of COVID-19 cases. In the next phase, Oklahoma will need to surge its hospital resources to address the crisis. This surge will involve increasing the capacity of existing hospitals, the number of licensed providers, and the amount of PPE available for use. Oklahoma can only successfully surge hospital resources when needed if Oklahoma preserves and reallocates existing resources during the mitigation stage to prepare for the surge.

14. Based on the looming threats from COVID-19 to PPE and the capacity of the health care system, and hearing from health professionals across the State, I recommended to Governor Stitt that he temporarily delay all elective surgeries or minor medical procedures that could decrease the availability of PPE or hospital capacity needed to address the COVID-19 crisis. We estimated that such a delay could preserve about 25% of PPE that would otherwise be used in the coming weeks.

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

16. Executed on this 2 day of April 2020.

Jerome Loughridge
Secretary of Health and Mental Health
State of Oklahoma
Oklahoma City, OK

Exhibit 2

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

SOUTH WIND WOMEN'S CENTER LLC, *et al.*,

Plaintiffs,

v.

J. KEVIN STITT, *et al.*,

Defendants,

No. 20-cv-277-G

DECLARATION OF CHRISTY J. MARESHIE, D.O.

I, Christy Jeannette Mareshie, declare the following:

1. I am an osteopathic medicine physician (D.O.) licensed to practice in the State of Oklahoma. I graduated from the Oklahoma State University College of Osteopathic Medicine in 2003, and I completed my residency in emergency medicine in Joplin, Missouri, in the Freeman Health System. I specialize in emergency medicine.

2. I have been board certified in emergency medicine since 2010, and will continue to be board certified through 2030. I am also a clinical profession of emergency medicine at the University of Oklahoma. I train its residents to be future emergency room physicians.

3. For nearly 15 years, I have worked as an emergency room physician at Hillcrest Medical Center in Tulsa, Oklahoma. Presently, I work nights, from 9 p.m. to 7 a.m. This has put me on the front lines of the COVID-19 pandemic. COVID-19 is very contagious—way more contagious than the flu, and more deadly. Its growth is exponential. Seemingly every shift, we are seeing a greater proportion of people who are testing positive for COVID-19 and in critical condition. And, as always, we simply don't know who will walk into our emergency room at any given moment. On one recent shift alone, I was exposed to the virus at least

twice. Overall, we have interacted with dozens of infected patients, and it is only getting worse.

4. Because the virus lives on surfaces for days and can easily be passed through the air, our main concern in the emergency department, as well as difficulty, is securing and replenishing the appropriate personal protective gear (PPE), i.e., masks, gloves, gowns. Thankfully, we are not entirely out of such gear. But because of our limited resources and necessity, we are reusing some PPE, like masks and gowns, from one room to another. This is risky as such can increase exposure, will potentially spread the virus, and create a gathering place for it at our facility. We are doing our best, but we do not presently have the capability to use new PPE for each new patient encounter. In general, much of the PPE resources are going to places like New York City and Washington, where the situation is dire.

5. By reusing materials, we are potentially spreading the virus without even knowing it. Sadly, the chances are likely that I will contract COVID-19 if we have to keep reusing N95 masks and gowns. But we have no choice at this point.

6. If I contract this virus, I may spread it to my immediate family and throughout the community.

7. I strongly support Governor Stitt's executive order to temporarily halt all elective surgeries and procedures to free up more PPE and supplies. The question is simple: Should we continue to use our limited PPE and other resources on elective procedures on healthy people, or should we save it for a person who has a heart attack and might die if we accidentally spread COVID-19 to that person? To me, on the front lines, this is a no-brainer.

8. Furthermore, there is no reasonable basis for restricting other elective surgeries or procedures in order to preserve PPE and exclude abortion, a mostly elective procedure performed on healthy women. It is nonsensical to carve out an exemption for abortion and

not for other procedures that arguably cause even greater inconvenience to patients when they are postponed, such as pacemaker implantation, gall bladder removal, knee replacement, etc. Once exceptions are made as to certain medical procedures, it would undermine and perhaps defeat the purpose of the executive order.

9. Of course, ruling out elective procedures is not easy on anyone. Rather, it requires a large sacrifice from the medical community and patients. We have a hospital full of skilled physicians who specialize in important procedures that cannot be done at this time. These doctors are foregoing money and having problems with sustaining their practice as a result, but they are complying, for the good of the public.

I state under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed this 2nd day of April, 2020 in Bixby, Tulsa County, Oklahoma.

CHRISTY J. MARESHIE, D.O.

Exhibit 3

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

SOUTH WIND WOMEN'S CENTER LLC, *et al.*,

Plaintiffs,

v.

J. KEVIN STITT, *et al.*,

Defendants,

No. 20-cv-277-G

DECLARATION OF JEREMY HANEY, M.D.

I, Jeremy Haney, M.D., declare the following:

1. I am a medical doctor (M.D.) licensed to practice in the State of Oklahoma. I attended the University of Oklahoma College of Medicine and completed my residency in anesthesiology at the University of Oklahoma Health Sciences Center.

2. I am the President of the Oklahoma Society of Anesthesiologists (OSA), which has 450 members, and the Vice Chair of US Anesthesia Partners of Oklahoma (USAP-Oklahoma). I practice at INTEGRIS Baptist Medical Center in Oklahoma City, specializing in anesthesiology. At INTEGRIS, I serve as the chair of our Anesthesia Care Transformation Team. Currently this team has been tasked to provide evidence based protocols manage the COVID-19 pandemic across the INTEGRIS Care system, which extends to Edmond, Oklahoma City, Yukon, Grove, Miami and other locations.

3. In general, anesthesiologists take care of surgical patients throughout their surgical experience which includes pre-operatively, intraoperatively, and postoperatively in recovery. In other words, we are involved in the vast majority of surgeries. Personally, I do anesthesia

for obstetric surgery, pediatric surgery, general surgery, and some cardiovascular surgery. I also work in labor and delivery placing epidurals for childbirth, and spinals for C-sections.

4. By mid-March of this year, I and numerous other Oklahoma anesthesiologists and physicians had grown to believe, firmly, that the COVID-19 pandemic had become severe enough to necessitate the emergency (and unfortunate) postponing of all elective medical procedures, among other drastic measures, both to flatten the exponential curve of the virus and to preserve vital medical resources that were quickly becoming unavailable. The OSA started calling for this to be done statewide on or around March 19, which was the same day that a number of state and local hospitals-implemented this policy internally. I repeated this call in a Tulsa TV news interview on March 20. Around the same time, other private medical groups were starting to push for a statewide end to elective surgeries, as well.

5. On March 22, the OSA placed a full-page "Open Letter to Oklahomans" in both *The Oklahoman* and the *Tulsa World* entitled "**Postpone Elective Surgeries <u>Now</u>!**"[1] In the letter, we argued that providers should "immediately postpone all elective, non-urgent surgeries" because "medical resources are going to be in scarce supply" and because "elective surgery is causing unnecessary community spread and utilizing supplies that are needed for critically ill patients effected by the COVID-19 pandemic." We applauded "the hospital systems and surgery centers of Oklahoma and their providers who have chosen to follow these guidelines of temporarily postponing elective surgeries to protect all Oklahomans." Finally, we noted that the American Society of Anesthesiologists, the Anesthesia Patient Safety Foundation, the American College of Surgeons, the American Academy of Orthopedic Surgeons, and the Ambulatory Surgery Center Association supported this postponement.

[1] Attachment A.

6. Later, we at OSA also spoke with the Secretary of Health Jerome Loughridge, who is on the Governor's COVID response team, pushing him for a postponement of elective procedures. We continued to press strongly on this point until, on March 24, Governor Stitt issued his order requiring medical providers in Oklahoma to "postpone all elective surgeries, minor medical procedures, and non-emergency dental procedures." This was absolutely the right call, but it was not an easy call, for him or for us.

7. Postponing all elective surgeries was necessary to preserve personal protective equipment (PPE). For surgery, during a pandemic with a highly contagious disease, full PPE absolutely must be worn which includes an N95 mask, eye shield, gown, and gloves. Due to the nature of COVID-19 being spread as an airborne aerosol, anyone in the operating room needs full PPE as well.

8. Unfortunately, PPE is in very short supply. Hospitals across the state and country have inadequate supplies and have been asking for donations of PPE equipment from the community. Orders that have been placed are being blocked by other countries that manufacture the PPE for use for their country. Even disinfectant/bleach wipes are in short supply. Physicians and hospital administrators are on phone calls daily with the public and private sectors about obtaining vital PPE.

9. Because of our limitations, we are reusing PPE. In the past surgical masks were one time use only. Now we are having to use one N95 mask for multiple days. This is occurring in our state and throughout the country.

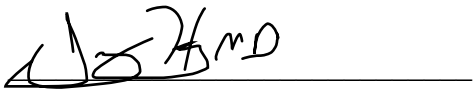
10. Postponing all elective surgeries was also necessary to prevent the spread of COVID-19. The biggest thing people don't realize is that we have to treat any patient that comes in for surgery as a COVID-positive patient because there are so many asymptomatic carriers. Asymptomatic patients scare me because they still pose the risk of spreading the virus. Some

patients with COVID-19 may never be symptomatic or others may become symptomatic several days after infection. You're going to get healthcare workers and everyone in a facility sick, if you're not anticipating asymptomatic patients. For us, this means that even recovery room nurses need to wear full PPE to avoid potential spread.

11. Hospitals and surgery centers have postponed a number of important medical procedures and surgeries: Total joint replacements, ear tubes, sinus surgeries, tonsils and adenoids, elective hysterectomies, tubal ligations, vasectomies, plastic surgery, circumcisions, cataracts, dental procedures, chronic pain procedures, elective spine surgeries for pain etc. Nothing about this is pandemic is easy for anyone. I'm not a salaried employee and if I'm not doing anesthesia for surgeries I'm not producing any income. Elective surgeries are a large proportion of my practice. Most of all, this is highly inconvenient for our patients. They have planned their finances and schedules around surgeries that are now postponed. Some of these patients situations are difficult to live with: cataracts, back pain, chronic pain etc. They are sacrificing as well.

12. Governor Stitt's order should apply to everyone and every elective procedure. Facilities battling the COVID-19 pandemic need access to all available PPE

I state under penalty of perjury that the foregoing is true and correct to the best of my knowledge. Executed this 2nd day of April, 2020 in Oklahoma City, Oklahoma.



Jeremy Haney, M.D.

Attachment A

Postpone Elective Surgeries Now!

An Open Letter to Oklahomans From the Oklahoma Society of Anesthesiologists

As our state and nation respond to the COVID-19 pandemic, medical resources are going to be in scarce supply. One way to alleviate this impending crisis is to immediately postpone all elective, non-urgent surgeries. The Oklahoma Society of Anesthesiologists is asking providers to postpone all surgery which wouldn't cause a negative impact to health by delay. Elective surgery is causing unnecessary community spread and utilizing supplies that are needed for critically ill patients effected by the COVID-19 pandemic.

We applaud the hospital systems and surgery centers of Oklahoma and their providers who have chosen to follow these guidelines of temporarily postponing elective surgeries to protect all Oklahomans. We urge others to adopt guidelines now to safeguard health professionals and the patients they serve.

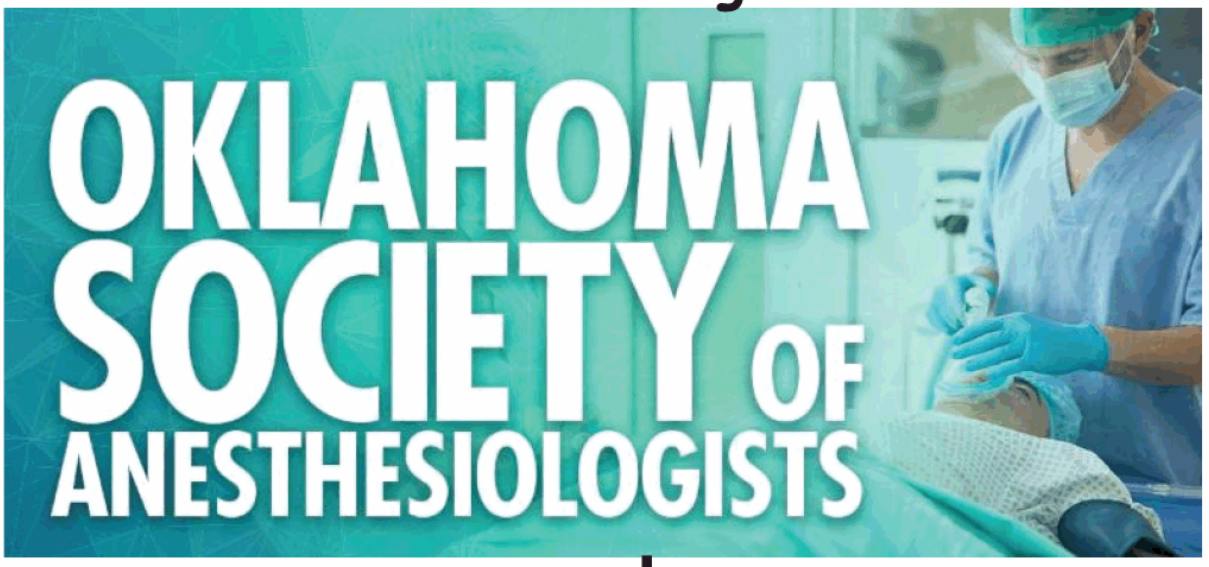
The Centers for Disease Control and Prevention (CDC) recommends we reduce non-urgent surgical, diagnostic and intervention procedures.

CDC COVID-19 guidelines advise the elderly and those with serious chronic medical conditions to stay at home as much as possible. This recommendation should be interpreted to include non-urgent surgery. Facilities should also consider social distancing and restrictions on patients and visitors who may be asymptomatic to ensure the well-being of their healthcare providers.

This message of health and safety brought to you by The Oklahoma Society of Anesthesiologists who joins with the American Society of Anesthesiologists, the Anesthesia Patient Safety

Foundation, the American College of Surgeons, American Academy of Orthopaedic Surgeons, and the Ambulatory Surgery Center Association in supporting the postponement of all elective surgeries until the Coronavirus pandemic is under control.

Join us in urging all providers in Oklahoma to postpone elective surgeries.



www.osahq.org

See this article in the e-Edition Here

Exhibit 4

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

SOUTH WIND WOMEN'S CENTER LLC, *et al.*,

Plaintiffs,

v.

J. KEVIN STITT, *et al.*,

Defendants,

No. 20-cv-277-G

DECLARATION OF MICHAEL T. VALLEY, M.D.

I, Michael T. Valley, M.D., declare the following:

1. I am a physician licensed to practice in the state of Minnesota. I am Board certified in Obstetrics and Gynecology and the subspecialty of Female Pelvic Medicine and Reconstructive Surgery (Urogynecology) and have been an active practicing physician for over 25 years, post residency. I currently am in a private group practice in Minnesota where I practice Obstetrics, Gynecology, and Urogynecology. I completed my residency training at the University of Minnesota in 1992, during which time and after I have performed several non-elective abortions and managed patients with complications from both surgical and medical (medication) abortion. I have also served as faculty at the University of Oklahoma and the University of Florida, Jacksonville, teaching residents and medical students.

2. This declaration contains my opinions, held to a reasonable degree of medical certainty, which are based on my years of experience as a practitioner and educator in Obstetrics and Gynecology.

3. Pregnancy is typically divided into three trimesters. The first trimester is generally defined as pregnancy up through 12 weeks gestation. "Weeks gestation" is defined as the number of

completed weeks since the last menstrual period (LMP). About 11% of all induced abortions are performed after the first trimester. Thus, the vast majority of induced abortions are performed in the first trimester. Of first-trimester abortion, about 75 percent are performed through a surgical procedure called suction dilation and curettage ("suction D&C"). A suction D&C uses a vacuum device to remove the pregnancy from the uterus. The risks of this procedure include infection, hemorrhage, uterine perforation and incomplete abortion resulting in retained portions of pregnancy. For the latter complication, a second surgical D&C is usually required.

4. For the second trimester, in the United States the "D&E" procedure is the most common pregnancy termination beyond 13 weeks gestation. The "D" stands for dilatation (opening) of the uterine cervix and the "E" for evacuation of the fetus from the uterus. Maternal risks of the D&E procedure include complications such as hemorrhage, infection, cervical laceration, uterine perforation, anesthetic reactions, re-operation for retained pregnancy tissue, and death.[1]

5. Finally, about 40 percent of early first-trimester abortions are medication abortions, using a combination of mifepristone and misoprostol to induce pregnancy. These abortions come with risks, as well, at a greater rate than surgical abortions at the same gestational age: mainly hemorrhage, and incomplete abortion resulting in retained portions of pregnancy**.** If a woman has hemorrhage or retained portions of pregnancy (failed medical abortion occurs about 8% of the time) they then require a D & C that utilizes more personal protective equipment (PPE). The fact that the U.S. Food and Drug Administration (FDA) has long required a Risk Evaluation and Mitigation Strategy (REMS) protocol is the best indication

[1] Patricia A. Lohr, Surgical Abortion in the Second Trimester, REPRODUCTIVE HEALTH MATTERS 16 (2008) 151–161.

that these risks exist. And risks, of course, can lead to complications, which can lead to surgeries, hospital use, and PPE use.

6. Notably, the abortion clinics in this case say: "Despite sometimes being referred to as 'surgical abortion,' procedural abortion is not what is commonly understood to be 'surgery'; it involves no incision or general anesthesia." (P.9) This is incorrect. Abortion is commonly understood as surgery, because it does involve anesthesia and is a surgical procedure that uses surgical instruments inserted into a woman's body and uterus. Moreover, surgical abortion has significant surgical risks.

7. In this case, the abortion clinics claim that continued pregnancy may require greater use of personal protective equipment (PPE) than elective abortion because women will have to make multiple visits to the doctor during pregnancy. This is mistaken on several accounts.

8. First, and most importantly, most women do not have high-risk pregnancies, and for them some prenatal visits during pregnancy can be temporarily postponed for a crisis or done through telehealth. In my practice we are currently doing a number of video and telephone prenatal visits with pregnant women, unless it is absolutely essential to have an in-person visit. This is limiting PPE use.

9. Second, although the clinics claim to be using "minimal" PPE (P.14), what they describe as minimal—gloves, shoe covers, protective eyewear, face shields, surgical masks, and gowns—is not minimal at all. That's the very PPE that is required in this pandemic, and it is what people are desperately looking to acquire. Moreover, it should be the case that the clinics are using all of that PPE at least twice over, for every single surgical abortion procedure, since there would be a minimum of two people in the room.

10. Third, unlike abortion or other surgical procedures, normal pregnancy care doesn't use PPE except for occasional use of gloves for an exam. Now, because of the pandemic, many

clinics are additionally using a mask when seeing patients in clinic, but that should also be true for the abortion clinics themselves. If open, it would be reckless of them not to use much larger amounts of PPE than normal to protect women and their staff, especially since (unlike our routine clinic check-ups) they are also performing surgery in their clinics.

11. Fourth, timing matters. The vast majority of PPE isn't needed during pregnancy until the end of the pregnancy, for childbirth. And presumably, for the patients involved here, that moment is several months away, which will, I hope, be beyond the shortage caused by this pandemic. So the claim that postponing abortions along with other elective surgeries and procedures actually causes more PPE usage ***now*** just doesn't make sense to me.

12. Given the current pandemic, I support postponing all elective surgeries to preserve vital PPE and prevent unnecessary spread of the disease. This includes abortion. Abortion is elective, and it is not essential OBGYN care, which is evidenced by the fact that the vast majority of OBGYNs—at least 85 percent—do not even perform abortions. Such actions in time of crisis actually protect women and abortion clinic provider and staff by limiting exposure and spread.

I state under penalty of perjury that the foregoing is true and correct to the best of my knowledge. Executed this 2nd day of April, 2020 in St. Louis Park, Minnesota.

Michael Valley, M.D.

Exhibit 5

Jay Weinstein, M.D., [redacted] M.D.
Script for Agent
Nova Health System/Reproductive Services

We are mandated by the state of Oklahoma to verbally give you the following information 72 hours prior to your procedure time. You will have to sign a form when you come in for your procedure certifying that you were given this information at least 72 hours before your abortion. As the physician's agent I will provide the information to you and you will be able to ask and answer questions. You will also have the opportunity to ask the physician questions and the physician will have the opportunity to ask you questions at the time of your appointment.

1. Your procedure will be performed by either Dr. Weinstein or Dr. [redacted]

2. The probable gestational age of your pregnancy at the time of your procedure is _____ weeks.

3. In general complications associated with full term childbirth occur more frequently and are more serious than those associated with abortion. Possible medical risks associated with continuing the pregnancy include: allergic reactions to anesthetics or other medications, bleeding, infection, complications with delivery including cesarean section, uterine injury requiring hysterectomy or causing infertility, vaginal injuries or lacerations causing hematomas or rectal injury, developing high blood pressure, toxemia, diabetes, blood clots (in the legs, pelvis or lungs) and severe post partum depression. The risk of maternal death is approximately 9 per 100,000 live births.

4. The possible medical risks associated with the abortion procedure include: allergic reactions to anesthetics or other medications, bleeding, infection, laceration, uterine perforation, injury to internal organs which may lead to infertility, repeat or incomplete abortion, continued pregnancy, severe emotional reaction, menstrual disorder, and blood clots (in the legs, pelvis or lungs). The risk of maternal death for first trimester abortions is approximately 1 per 200,000 procedures.

   If you have questions you would like to ask the physician at this time, please share them with me. Most questions can be answered by phone and the doctor can call you at his/her convenience. If you want to make an appointment to talk to the doctor, there will be a $25.00 charge and you will need to wait 72 hours after the appointment for your procedure. Would you like the doctor to call you? *(Must record answer on Intake screen.)* What is the best number for the doctor to contact you?

   In addition, I am required to tell you that:

5. Perinatal hospice services are available if your pregnancy has been diagnosed with a fetal anomaly incompatible with life, this service is an alternative to abortion.

6. Medical assistance benefits may be available for prenatal care, childbirth, and neonatal care.

7. The father is liable to assist in the support of the child even in instances in which the father has offered to pay for the abortion.

8. Ultrasound and heart beat monitoring is available to you upon your request.

9. The State Board of Medical Licensure and Supervision has prepared printed materials that describe the fetus and list agencies that offer alternatives to abortion. You have the option of reviewing these materials or not. You can view them online at www.awomansright.org or I can mail the printed materials to you. Would you like to review the material? *(Must record answer on the Intake screen, if yes offer to mail the materials.)*

RS0010

LOK/013

Exhibit 6

Exhibit 6

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;

LARRY A. BURNS, D.O., on behalf of himself, his staff, and his patients; and

COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, INC., on behalf of itself, its physicians and staff, and its patients,

Plaintiffs,

v.

J. KEVIN STITT, *in his official capacity as* Governor of Oklahoma,

MIKE HUNTER, *in his official capacity as* Attorney General of the State of Oklahoma;

DAVID PRATER, *in his official capacity as* District Attorney for Oklahoma County;

GREG MASHBURN, *in his official capacity as* District Attorney for Cleveland County

GARY COX, *in his official capacity as* Oklahoma Commissioner of Health; and

MARK GOWER, *in his official capacity as* Director of the Oklahoma Department of Emergency Management,

Defendants.

Case No: 20-CV-277-G

DECLARATION OF ROBERT L. MARIER, M.D., M.H.A.

I, Robert L. Marier, M.D., M.H.A., declare the following:

1. I am the System Vice Chairman of Hospital Medicine for the Ochsner Health System located in Louisiana. I served as a member of the Hospital's Medical Staff Credentialing Committee until recently. I make this Declaration based upon my personal knowledge and am competent to testify thereto.
2. I received my M.D. degree from Yale University School of Medicine, New Haven, Connecticut in 1969. My post-graduate training in internal medicine took place at Massachusetts General Hospital in Boston, Massachusetts. I served as an Epidemic Intelligence Service Officer, National Center for Disease Control, USPHS, Atlanta, Georgia from 1971-1973, followed by a fellowship in infectious disease at Yale University.
3. In 1978, I joined the faculty of LSU School of Medicine, where over the years I served as Professor of Medicine and Public Health, Medical Director of Charity Hospital, Director of the Public Hospital System in the State of Louisiana, and Dean of the Schools of Medicine and Public Health. In 2006, I was appointed to be Executive Director of the Louisiana State Board of Medical Examiners—a position I held until 2012, when I joined the staff at Ochsner Medical Center.
4. I am Board Certified in Internal Medicine and Infectious Diseases and am a Diplomat of the American Board of Medical Management (now known as the Certifying Commission in Medical Management). I hold a Master's degree in health system administration from Tulane University School of Public Health.

5. I am aware of Governor Stitt's Executive Order that postpones all "elective surgeries, minor medical procedures, and non-emergency dental procedures" in Oklahoma during the coronavirus disease 2019 (COVID-19) outbreak.
6. Patients with COVID-19 infection may infect others prior to the onset of symptoms, especially in the health care setting due to the proximity of contact. We have had two such cases over the past few days at Ochsner Medical Center.
7. The onset and duration of viral shedding and period of infectiousness for COVID-19 are not yet known.
8. According to the United States Centers for Disease Control (CDC)[1]
    a. It is possible that SARS-CoV-2 RNA may be detectable in the upper or lower respiratory tract for weeks after illness onset, similar to infection with MERS-CoV and SARS-CoV. However, detection of viral RNA does not necessarily mean that infectious virus is present. Asymptomatic infection with SARS-CoV-2 has been reported, but it is not yet known what role asymptomatic infection plays in transmission. Similarly, the role of pre-symptomatic transmission (infection detection during the incubation period prior to illness onset) is unknown. Existing literature regarding SARS-CoV-2 and other coronaviruses (e.g. MERS-CoV, SARS-CoV) suggest that the incubation period may range from 2-14 days.
    b. Very limited data are available about detection of SARS-CoV-2 and infectious virus in clinical specimens, so it is unknown exactly which

[1] *See* https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html.

bodily fluids may transmit the virus, so that we have a full picture of how to prevent transmission between people. SARS-CoV-2 RNA has been detected from upper and lower respiratory tract specimens, and SARS-CoV-2 has been isolated from upper respiratory tract specimens and bronchoalveolar lavage fluid. SARS-CoV-2 RNA has been detected in blood and stool specimens, but whether infectious virus is present in extrapulmonary specimens is currently unknown. The duration of SARS-CoV-2 RNA detection in upper and lower respiratory tract specimens and in extrapulmonary specimens is not yet known but may be several weeks or longer, which has been observed in cases of MERS-CoV or SARS-CoV infection. While viable, infectious SARS-CoV has been isolated from respiratory, blood, urine, and stool specimens, in contrast, viable, infectious MERS-CoV has only been isolated from respiratory tract specimens. It is not yet known whether other non-respiratory body fluids from an infected person, including vomit, urine, breast milk, or semen, can contain viable, infectious SARS-CoV-2.

9. Health Care workers caring for patients under investigation for COVID 19 or for patients with confirmed COVID 19 infection routinely wear face masks and other personal protective equipment (PPE).

10. Health care workers do not routinely wear face masks and other PPE when caring for patients who are not under investigation for COVID 19 or for patients with confirmed infection.

11. Wearing face masks and other PPE when caring for patients under investigation for COVID 19 or for patients with confirmed COVID 19 infections reduces the risk of transmission but does not eliminate it.
12. Not wearing face masks and other PPE when caring for patients, even those who are not under investigation for COVID 19, exposes health care workers to transmission of infection from patients who are incubating infection and asymptomatic.
13. Not wearing N95 face masks in particular when caring for patients, even those who are not under investigation for COVID 19, exposes health care workers to an increased risk of transmission of infection from patients who are incubating infection and asymptomatic.
14. The President and CEO of Ochsner Health reported on March 25, 2020, that 60 employees have tested positive for COVID-19, and approximately 300 employees have been quarantined attesting to the importance paragraphs 11 through 13 above.
15. Given the risk of transmission in health care settings, Governor Stitt has a sound basis for limiting all surgeries except those that are immediately medically necessary so as to prevent the spread of COVID 19.

DECLARATION UNDER PENALTY OF PERJURY

I, Robert L. Marier, M.D., M.H.A., a citizen of the United States and a resident of Louisiana, hereby declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing Declaration is true and correct.

Executed on this 2 day of April 2020

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

Exhibit 7

IN THE DISTRICT COURT OF OKLAHOMA COUNTY
STATE OF OKLAHOMA

SOUTH WIND WOMEN'S CENTER LLC, D/B/A TRUST WOMEN OKLAHOMA CITY; *et al.,*

Plaintiffs,

v.

MIKE HUNTER, in his official capacity as OKLAHOMA ATTORNEY GENERAL; *et al.*

Defendants,

No. CV-2019-2506
Hon. N. Mai

DECLARATION OF DONNA HARRISON, M.D.

I. BACKGROUND

1. I, Donna Harrison, M.D., am a physician licensed to practice medicine in Michigan. I am certified by the American Board of Obstetricians and Gynecologists, and I have held this certification since 1993. I graduated from the University of Michigan Medical School in 1986, and I completed residency training in Obstetrics and Gynecology in 1990 at St. Joseph Mercy Hospital (a University of Michigan affiliate hospital in Ypsilanti). I entered private obstetrical practice in 1991 in Ann Arbor. I also served as Associate Professor in the Department of Obstetrics and Gynecology at the University of Michigan until 1993 when I joined a multispecialty group in an underserved rural area of Michigan. I continued in private practice in this underserved area, including serving as sexual abuse examiner for Cass County, Michigan, until 2000. Further details of my training and professional background are given in my resume, provided as Attachment A.

2. Since 1996, I have closely scrutinized the U.S. Food and Drug Administration (FDA) approval process for Mifeprex (a/k/a mifepristone and RU-486), and I have conducted extensive research into the safety and efficacy of abortion-inducing drugs, authoring several papers on the subject. From 2000-2006, I was Chairman of the Subcommittee on Mifeprex for the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG). Since 2000, I have focused my professional activities on teaching, writing, and research for AAPLOG. Since 2013, I have served as AAPLOG's Executive Director.

3. I spend approximately 50 hours per week reviewing the medical literature for the effects of abortion on women, teaching physicians and other health care personnel about the medical literature, and making that information known by way of scientific publication and through the AAPLOG website. I have devoted particular attention to abortions performed through the administration of drugs.

4. In the past four years, I have testified as an expert in cases in Indiana, Missouri, Arkansas, Illinois, and Oklahoma, in both state and federal court.

5. I have been asked by the Oklahoma Attorney General to opine regarding the Oklahoma County District Court Case No. CV-2019-2506, a legal action brought against various Oklahoma officials by South Wind Women's Center, Dr. Colleen McNicholas, and Bridget Van Treese ("Legal Action"). The Legal Action challenges longstanding Oklahoma laws requiring that abortions be performed in person by licensed physicians. The opinions in this declaration are based on my education, training, experience, and ongoing familiarity with the medical literature. These opinions are my own, and do not represent any group.

II. OPINION

6. I have reviewed the Oklahoma statutes requiring licensed physicians to provide abortions in person. I have also reviewed Plaintiffs' submitted testimony. I will focus this affidavit on three important topics: 1) The medical risks inherent in medical abortion, 2) The deficiencies in telemedicine to address these risks, and 3) responses to Plaintiffs' testimony.

A. Medical abortion carries significant risks, including hemorrhage, retained tissue, and need for emergency surgical intervention.

7. In a medical abortion, per the current FDA protocol, women are instructed to take 200 mg of Mifeprex on day one, then 24-48 hours later "place two 200 [microgram] misoprostol tablets in each cheek pouch (the area between the cheek and gums) for 30 minutes and then swallow any remnants."[1]

8. Mifeprex is a drug that blocks the action of a natural pregnancy hormone called progesterone by binding with a woman's progesterone receptors on the nuclear membranes of cells in the uterus, ovary, brain, breast, and immune system. With mifepristone blocking the connection of progesterone with progesterone receptors in the uterus of a pregnant woman, the mother's cells in the placenta stop functioning, which leads to the death of the human embryo through, in essence, starvation.[2] In other words, if it works as intended in this context, Mifeprex results in the death of an unborn human being.

9. Misoprostol is a synthetic prostaglandin which is used to prevent gastric ulcers in patients who have a high risk of developing a gastric ulcer, or who are on drugs which induce gastric ulcers.[3]

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[1] U.S. Food & Drug Administration (FDA), *Mifeprex Medication Guide*, 3 (2016), provided as Attachment B.
[2] Etienne-Emile Baulieu & Sheldon J. Segal, *Reproductive Biology: The Antiprogestin Steroid RU486 and Human Fertility Control. Proceedings of a Conference on the Antiprogestational Compound RU486* (Plenum Press, N.Y. 1985).
[3] FDA, *Cytotec* (*Misoprostol) Medication Guide*, 11 (2009), https://www.accessdata.fda.gov/drugsatfda_docs/label/2009/019268s041lbl.pdf.

FDA Warnings and Adverse Events Reporting

10. Both the FDA and drug manufacturers have acknowledged that the use of Mifeprex/misoprostol regimens to induce an abortion poses health risks for pregnant women. The final printed labeling (FPL) shaped and approved by the FDA warns that "About 85% of patients report at least one adverse reaction following administration of MIFEPREX and misoprostol, and many can be expected to report more than one such reaction."[4] These reactions include, but are not limited to, vomiting, headache, uterine hemorrhage, viral infections, and pelvic inflammatory disease.[5]

11. The FDA considers Mifeprex complications serious and frequent enough to issue a black box warning to prescribers titled **"WARNING: SERIOUS AND SOMETIMES FATAL INFECTIONS OR BLEEDING."**[6] In addition, the FDA has instituted a Risk Evaluation and Mitigation Strategy (REMS) for Mifeprex.[7] According to the FDA, REMS "is a drug safety program" that the FDA "can require for certain medications with serious safety concerns."[8] The FDA goes on to emphasize that "[w]hile all medications have labeling that informs health care stakeholders about medication risks, only a few medications require a REMS."[9] Mifeprex is one of those few medications: in its own words, in 2018 "the agency determined that a REMS . . . continues to be necessary to ensure the safe use of Mifeprex."[10] The REMS prohibits use of Mifeprex in ways other than allowed by the FDA.

12. Moreover, the FDA reports that, as of December 31, 2018, over 4,000 women in the United States have experienced "adverse events" after using mifepristone for the termination of pregnancy.[11] Among those adverse events were 24 deaths, 1,042 hospitalizations, 599 blood transfusions, and 412 infections.[12] This last figure includes 69 severe infections, which the FDA says "generally result in death or hospitalization for at least 2-3 days, require intravenous antibiotics for at least 24 hours and total antibiotic usage for at least 3 days…." The same report indicates that there have been "11 additional reported deaths

[4] Attachment B, FDA Mifeprex Medication Guide at 7.
[5] *See, e.g.*, *id.* at 7-8.
[6] *Id.* at 1-2.
[7] FDA, *Mifeprex (mifepristone) Information*, Feb. 5, 2018, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information, provided as Attachment C; FDA, *Warning Letter: Rablon.* (2019), https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/warning-letters/rablon-1111111-03082019, provided as Attachment D.
[8] FDA, *Risk Evaluation and Mitigation Strategies* (*REMS*) 1 (2019), https://www.fda.gov/drugs/drug-safety-and-availability/risk-evaluation-and-mitigation-strategies-rems, provided as Attachment E.
[9] *Id.*
[10] Attachment C, FDA Mifeprex Info at 1.
[11] FDA, *Mifepristone U.S. Postmarketing Adverse Events Summary Through 12/31/2018*, https://www.fda.gov/media/112118/download, provided as Attachment F.
[12] *Id.*

in women in foreign countries who used mifepristone for medical termination of pregnancy."[13]

Underreporting of Complications

13. These figures do not tell the whole story, either. The true number of complications from use of a Mifeprex abortion regimen is unknown, as there are widespread inadequacies in reporting. The FDA itself admits, for example, that it "does not receive reports for every adverse event … that occurs with a product."[14] This is in part because healthcare professionals are not required to report adverse events; rather, such reporting is voluntary.[15] On top of that, a 2006 review, conducted by Dr. Margaret Gary and myself, of official Adverse Event Reports (AERs) submitted to the FDA related to the use of the Mifeprex drug regimen, found that "AERs relied upon by the FDA to monitor mifepristone's postmarketing safety are grossly deficient due to extremely poor quality."[16] Our review concluded, "[A] majority of the AERs analyzed do not provide enough information to accurately code the severity of the adverse event in question. The deficiencies were so egregious in some instances as to preclude analysis."[17]

14. One source of potential underestimation of the true number of complications from the use of the Mifeprex abortion regimen is patients who seek hospital treatment for complications and do not inform the hospital that the complications stem from an abortion attempt. Because miscarriage and abortion may present initially with the same symptoms,[18] this is relatively easy to do, and it is condoned or even encouraged by some. One international organization of medical professionals and others dedicated to "access to abortion," for example, advises that a woman who seeks medical care because of complications from a Mifeprex abortion "does not need to tell a health care provider that she took abortion pills."[19]

Medical versus surgical abortions

15. Even with inadequate reporting and likely underreporting, the existing medical evidence shows that there are more complications from medical abortions than from surgical abortions. Studies comparing the outcome of surgical versus medical abortion have repeatedly

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[13] *Id.*
[14] FDA, *Questions and Answers on FDA's Adverse Event Reporting System (FAERS)*, 2 (2018), https://www.fda.gov/drugs/surveillance/questions-and-answers-fdas-adverse-event-reporting-system-faers, provided as Attachment G.
[15] *Id.* at 1.
[16] Margaret M. Gary & Donna J. Harrison, *Analysis of Severe Adverse Events Related to the Use of Mifepristone as an Abortifacient*, 40 ANNALS PHARMACOTHERAPY 2, 1 (Feb. 2006), provided as Attachment H.
[17] *Id.* at 5.
[18] Women's Health Network, *Health Facts: Abortion with Pills and Spontaneous Miscarriage* (Aug. 2019), https://nwhn.org/abortion-pills-vs-miscarriage-demystifying-experience/.
[19] Women Help Women, *Will a doctor be able to tell if you've taken abortion pills* (Sept. 2019), https://womenhelp.org/en/page/1093/will-a-doctor-be-able-to-tell-if-you-ve-taken-abortion-pills.

demonstrated that medical abortions have a greater risk of hemorrhage, infection, continued pregnancies, retained tissue, and need for emergency reoperation than surgical abortions.[20]

16. A major review of nearly 7,000 abortions performed in Australia in 2009 and 2010 found that 3.3 percent of patients who used mifepristone in the first trimester required emergency hospital treatment, in contrast to 2.2 percent of patients who underwent surgical abortions.[21] And women receiving medical abortions were admitted to hospitals at a rate of 5.7 percent following the abortion, as compared with 0.4 percent for patients undergoing surgical abortion.[22]

17. Another study analyzed high-quality registry data obtained from nearly 50,000 women in Finland who underwent abortions from 2000-2006 with a gestational duration of 63 days or less. [23] This study found that the overall incidence of immediate adverse events is four-fold higher for medical abortions than for surgical abortions.[24] In particular, this study indicated that hemorrhage and incomplete abortion are more common after medical abortions; the incidence of hemorrhage was 15.6 percent following medical abortions, compared to 2.1 percent for surgical abortions, and 6.7 percent of medical abortions resulted in incomplete abortion, compared with 1.6 percent of surgical abortions.[25]

18. Even the American College of Obstetricians & Gynecologists (ACOG), an organization dedicated to pro-abortion political advocacy,[26] in a Practice Bulletin which was co-authored by Dr. Grossman, acknowledges that "[c]ompared with surgical abortion, medical abortion takes longer to complete, requires more active patient participation, and is associated with higher reported rates of bleeding and cramping." [27] Similarly, one of the self-proclaimed "authoritative" studies authored and relied upon by Dr. Grossman found that the overall complication rate for medical abortion (5.2%) was *four times higher* than the rate for first-trimester surgical abortion (1.3%).[28]

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[20] *See* Ushma D. Upadhyah et al., Incidence of Emergency Department Visits and Complications After Abortion, 125 J. OBSTET. GYNECOL. 1, 175, 181 (Jan. 2015), attached as Attachment I; Ea Mulligan & Haley Messenger, *Mifepristone in South Australia: The First 1343 Tablets*, 40 AUSTRALIAN FAMILY PHYSICIAN 5, 343 (May 2011), attached as Attachment J; Maarit Niinimaki, et. al., *Immediate Complications After Medical Compared with Surgical Termination of Pregnancy,* 40 J. OBSTET. GYNECOL. 4, 795 (Oct. 2009), provided as Attachment K.

[21] Attachment J, Mulligan.

[22] *Id.*

[23] Attachment K, Niinimaki.

[24] *Id.*

[25] *Id.*

[26] *See* Amicus Br. of Amer. Assoc. of Pro-Life Obstetricians and Gynecologists, *June Medical Services, LLC v. Gee*, 2019 WL 7397763 (Dec. 27, 2019).

[27] The American College of Obstetricians and Gynecologists, *Practice Bulletin: Medical Management of First-Trimester Abortion*, 143, 1 (March 2014), provided as Attachment L.

[28] Attachment I, Upadhyay at 175.

Hemorrhage

19. It is undeniable that hemorrhaging is a risk of using Mifeprex for abortion. This risk comes from mifepristone action at the cellular level, which blocks the ability of the uterus to control hemorrhage.[29] Again, the Finland study cited above indicated that 15.6 percent of women experienced hemorrhage after a medical abortion,[30] and the FDA has reported that at least 599 women have required blood transfusions after medical abortion.[31]

20. A recent and well-publicized clinical trial attempt by Dr. Mitchell Creinin is an example of the common risk of hemorrhage following Mifeprex abortion. This trial, designed to test the efficacy of medication abortion "reversal" protocols, was halted for safety considerations due to hemorrhaging.[32] Five women were given mifepristone alone, and two of those five (40%) had massive hemorrhage requiring emergency surgery, one of which required a blood transfusion. By contrast, in the comparison group with women taking mifepristone plus additional progesterone, only one woman had excessive bleeding, which stopped spontaneously without surgery.[33] (Progesterone counteracts the effect of mifepristone.)

Infection/sepsis

21. The risk of infection is also significant, since both Mifeprex[34] and misoprostol[35] depress a woman's immune response to infection, which can allow simple infections to become overwhelming and lead to fatal sepsis. In fact, this concern about serious infections led Planned Parenthood to abandon the off-label use of misoprostol in the vagina and substitute instead the off-label use of misoprostol in the cheek (buccal administration).[36]

Ectopic Pregnancy

22. An ectopic pregnancy occurs when a woman's embryo implants outside of the uterus, most often in the woman's fallopian tube. A woman who has an ectopic pregnancy may experience the same symptoms as a woman who has an early pregnancy in her womb.

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[29] Ralph P. Miech, *Pathopharmacology of excessive hemorrhage in mifepristone abortions,* 41 ANNALS PHARMOCOTHERAPY 12, 2002-07 (Dec. 2007).
[30] Attachment K, Niinimaki.
[31] Attachment F, Mifepristone AER at 2.
[32] Mitchell D. Crenin, et al., *Mifepristone Antagonization With Progesterone*, 135 J. OBSTET. GYNECOL. 1, 158-165 (Jan. 2020), provided as Attachment M.
[33] *Id.*
[34] *See* Jeanette I. Webster & Ester M. Sternberg, *Role of the Hypothalamic-Pituitary-Adrenal Axis, Glucocorticoids and Glucocorticoid Receptors in Toxic Sequelae of Exposure to Bacterial and Viral Products*, 181 J. ENDOCRINOLOGY, 207-21 (2004); Ralph P. Miech, *Pathophysiology of Mifepristone-Induced Septic Shock Due to Clostridium Sordellii*, 39 ANNALS PHARMOCOTHERAPY (Sept. 2005).
[35] D.M. Aronoff, et al., *Misoprostol Impairs Female Reproductive Tract Innate Immunity against Clostridium sordellii*, 180 J. IMMUNOLOGY 12, 6 (June 2008).
[36] M. Fjerstad et al., *Rates of Serious Infection after Changes in Regimens for Medical Abortions,* 361 NEW ENG. J. MED., 145-51 (2010).

Ruptured ectopic pregnancy is a leading cause of maternal mortality in the first trimester of pregnancy. Critically important, the only way to accurately diagnose an ectopic pregnancy is by the use of ultrasound to visualize the inside of the womb and locate the fetal pole.

23. If a woman who has an ectopic pregnancy is given mifepristone, she is in significant danger of the ectopic pregnancy rupturing, which will cause massive internal bleeding. Thus, if the location of the pregnancy cannot be confirmed by ultrasound, that is an absolute contraindication to giving mifepristone for abortion.[37] This is especially so because the symptoms of a rupturing ectopic pregnancy are identical to the symptoms that a woman experiences when she has a mifepristone abortion: bleeding, cramping and severe abdominal pain.[38] In other words, if an ectopic pregnancy has been missed, a woman could be in significant danger after taking mifepristone and believe the symptoms she is experiencing are normal.

Overall complication rates

24. Plaintiffs claim that "[c]omplications from medication abortion are extremely low."[39] This is misleading, at best, as medical evidence shows complications are common.

25. The most widely accepted definition for the frequency of drug complications is given by the Council for International Organizations of Medical Sciences (CIOMS), an international, non-governmental, non-profit organization established jointly by World Health Organization and UNESCO in 1949. The CIOMS training manual on medicine safety states that "adverse drug reactions" are "very common" if they occur in over 10% of cases and "common (frequent)" if they occur between 1 and 10% of the time.[40]

26. Published studies show that serious complications from drug-induced abortions are in the range of 3-5%, if not greater. The aforementioned Australian study, for example, found that 3.3% of patients who used mifepristone in the first trimester required emergency hospital treatment.[41] And the study from Finland found that 15.6% of women experienced hemorrhage after a medical abortion, that 6.7% of women had incomplete abortions, and that 5.9% required surgery to complete the abortion.[42] Using the CIOMS criteria, this means complications from medical abortions are "common" or "frequent."

27. The authoritative study that Dr. Grossman relies upon (and co-authored) to state that abortion is "safe" doesn't actually contradict this. Rather, that study explicitly found that the overall complication for abortion was 2.1% and the overall complication rate for medical abortion was 5.2%—the latter figure being "consistent with intervention rates found

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[37] Attachment B, FDA Mifeprex Med. Guide at 4.
[38] *Id.* at 6.
[39] Plaintiffs' Memorandum at 4.
[40] World Health Organization, *Medication Safety Training Course* at 10, https://www.who.int/medicines/areas/quality_safety/safety_efficacy/trainingcourses/definitions.pdf.
[41] *See* Attachment J, Mulligan; Attachment K, Niinimaki.
[42] Attachment K, Niinimaki.

in other studies," according to authors.[43] However, Dr. Grossman states a "major" complication rate of 0.31%. The "0.31%" quoted rate comes from what Dr. Grossman and his co-authors call the "major" complication rate.[44] But their criteria for "major" is excessively narrow, including only hospital admission (not Emergency Room visits), surgery (but not D&C for retained tissue), or blood transfusion.[45] This means that an emergency room visit, without a subsequent hospital admission, was not considered "major." Nor was any hemorrhage that didn't lead to a blood transfusion. This point is troubling, since in my review of the FDA adverse event reports, there were several women who had severe hemorrhages—losing nearly half of their blood—without a transfusion. The authors' definition of "surgery" also apparently excluded subsequent *surgical* abortions necessitated by a medical abortion failure, even though that is an undoubtedly a significant surgical complication. In addition the authors excluded seizures[46] from "major complications" as well as and allergic reactions regardless of severity, and any cases where an exact diagnosis could not be determined from the coding records. Finally, the authors admitted that "we could not assess whether any of the complications lead to deaths"—*i.e.*,[47] the study couldn't and didn't measure the most significant "major" complication.

B. Telemedicine is a questionable method by which to address known patient risks with Mifeprex abortions.

28. Providing medical abortion through telemedicine is problematic for at least three reasons: (1) the seriousness and risks of medical abortion are trivialized by the telemedicine approach; (2) a thorough and definitive in-person examination is needed and better ensured by having a physician present and involved; (3) an in-person meeting with a physician encourages future interaction and availability for follow-up and complication management.

Seriousness and Risks of medical abortion trivialized by telemedicine approach

29. As detailed above the decision to have a Mifeprex abortion is not only a decision to end the life of a completely separate human being, but also involves serious risks to the woman, including the risk of death. These risks increase as the pregnancy advances, and thus each woman should have a detailed discussion of the risks to her, tailored to her specific circumstances, by someone who is knowledgeable about her individual medical history, physical exam and individual risks. This is not a trivial discussion, and the vending machine approach of telemedicine abortion trivializes the seriousness of this decision-making process.

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[43] Attachment I, Upadhyaha at 175.
[44] *Id.*
[45] *Id.* at 176, 180.
[46] *Id.* at 176.
[47] *Id.* at 182.

The 2011 telemedicine paper by Grossman included a patient comment which illustrates this issue, stating "I am always generally more comfortable dealing with serious issues in person."[48]

Need for thorough evaluation by a physician

30. Mifeprex is contraindicated in a number of instances, including when ectopic pregnancy is suspected or confirmed; when there is chronic adrenal failure; when there is concurrent long-term corticosteroid therapy or anti-coagulant therapy; when the patient is allergic to mifepristone, misoprostol, or other prostaglandins; when the patient has inherited porphyria; and when the patient has an IUD in place.[49]

31. These contraindications require close attention to patient history and medications as well as a thorough physical examination by a physician capable of diagnosing hemorrhagic disorders, porphyria, adrenal failure, ectopic pregnancy, etc. A pelvic examination is required to rule out undiagnosed adnexal mass and look for the presence of an IUD, as well as to check for tenderness consistent with pelvic inflammatory disease. It is the responsibility of the prescribing physician to ensure that the patient does not have any of these contraindications prior to prescribing Mifeprex. Dr. Grossman claims that screening women for contraindications "can be done with equal safety regardless of whether the physician is physically present,"[50] but presents no real evidence especially for the diagnosis of pelvic infections, undiagnosed adnexal masses and uterine abnormalities making emergency surgical abortion more difficult. Further, even if an individual abortion clinic developed some safeguard to ensure the accurate diagnosis of all of the contraindications, that is no guarantee that it *will* be done with equal safety if medical abortion is thrown open to the practice of telemedicine. Dr. Grossman, after all, surely cannot vouch for the quality of the screeners at every present and future telemedicine-practicing abortion clinic in Oklahoma.

32. Along these lines, Dr. McNicholas presents a concerning and confusing picture of what abortion by telemedicine would actually entail in Plaintiffs' clinic, if this lawsuit were to prevail. Plaintiffs describe a telemedicine encounter that raises significant concerns about the adequacy of informed consent, and about coercion. The scenario presented, where the patient does not meet the physician until she is handed the mifepristone stands in sharp contrast to standard surgical care in which the surgeon examines, diagnoses, and discusses treatment options with the woman prior to commitment to a surgical procedure.

33. Plaintiffs indicate that the patient will be screened by the scheduler, who "will screen the patient to determine whether they are a potential candidate for medication abortion, aspiration abortion, or both." [51] It is not clear what training this "scheduler" will have, and how this "scheduler" will determine who is and who is not a candidate for Mifeprex abortion,

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[48] Daniel Grossman, *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*, 118 J. OBSTET. GYNECOL. 2, 302 (Aug. 2011).
[49] Attachment B, FDA Mifeprex Med. Guide at 4-5.
[50] Grossman Affidavit at 12.
[51] McNicholas Affidavit at 6.

surgical abortion or both. The determination of who is a candidate for a Mifeprex abortion involves not only gestational age, but also ruling out contraindications as per the FDA label. This kind of discernment requires medical training.

34. Dr. McNicholas indicates that "the patient will be provided with certain information that Oklahoma has mandated that abortion patient receive."[52] If this mandated information includes informed consent, then it is of grave concern that the "scheduler" is the one (apparently) doing the informed consent. An informed consent process should entail a discussion of specific risks, complications, and alternatives. Such patient specific consent necessitates a thorough history, a physical examination, and the ability of that "scheduler" to diagnose medical contraindications. Such skills are typically not in the ability of "schedulers" who are not formally trained in diagnosis and treatment.

35. According to Dr. McNicholas, the ultrasound will be performed by "a trained ultrasound technician."[53] This is also concerning since there is no mention of any actual sonography credentialing or certification by any recognized radiological or sonographic certifying body. An ambiguous phrase such as "a trained ultrasound technician" could include non-medical staff that has performed a few ultrasounds but is not actually certified. There are many other aspects to an ultrasound examination beyond gestational age, including the location of the placenta, the position of the uterus, the presence of a uterine septum, whether or not a woman has fibroids, etc., all of which become important if the woman has a subsequent hemorrhage requiring emergency surgery. Will the person performing the ultrasound be qualified to evaluate these abnormalities?

36. Ultrasound certification is critically important since by Plaintiffs' description the ultrasound gestational age dating appears to be the major criteria used by the remote physician to determine a woman's eligibility for medical abortions. Thus errors in gestational age caused by poor sonographic dating can have tremendous implications when discussing risks, because the risks of a mifepristone abortion increase with increasing gestational age.

37. The fourth step outlined by Dr. McNicholas is that patients will meet with "clinic staff for a consultation to discuss their decision, the process of medication abortion and what they should expect during their consultation with the physician and after they leave the clinic."[54] This is concerning as the "clinic staff" is not identified as someone with any formal medical training or credentialing. As per Dr. McNicholas' testimony, this "clinic staff" is doing a high level medical interaction with the patient, including apparently an informed consent discussion, as well as conveying medical information about the procedure, the risks and the expected complications. This is the kind of discussion that is expected between the surgeon and his or her patient in normal medical practice.

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[52] *Id.*
[53] *Id.* at 6.
[54] *Id.* at 6-7.

38. The issue of coercion in the process described by Plaintiffs is also of concern. It appears from Dr. McNicholas' testimony that the first time the patient sees the treating physician is immediately before she is handed the mifepristone.[55] At that point, the physical, psychological, and financial investment in the abortion would make it very difficult for a woman to choose any other option but to proceed with the abortion. The pressure on the patient at that point significantly compromises a patient's free and full informed consent prior to an elective procedure.

Follow-up availability

39. Dr. Grossman also claims that in-person treatment from a physician is irrelevant because when complications from a medical abortion do arise "they occur *after* the patient has left the clinic."[56] This presents a startlingly bleak and shallow picture of the physician-patient relationship, which is not supposed to end just because a patient goes home. Instead, a physician overseeing a procedure is supposed to be available to manage known complications from that procedure. That is difficult if the physician is in a remote location.

40. It would be unethical for a surgeon to start a procedure and then be unavailable to manage known complications from that surgery. A surgeon who simply tells the patient to go to a local emergency room if there is a complication risks a malpractice suit for patient abandonment, as well as risking the loss of hospital privileges. But, as Dr. Grossman's language inadvertently indicates, that is in effect what could happen with telemedicine abortions. Once the patient is out of the clinic, not even having met the physician in person, they risk no longer being considered the clinic or the physician's responsibility.

41. Unfortunately, even without telemedicine, the scientific literature indicates that this approach is pervasive in the industry. It is undeniable that many women report to emergency rooms rather than return to the clinic where they obtained the abortion. Dr. Grossman's own co-authored "authoritative" article indicates as much when it states that "complication rates are underestimated by low follow-up rates" and that "[p]ublished complication rates are considered incomplete because they usually do not include those diagnosed at sites other than the original source of care."[57] This trend is also why studies that include emergency room complications tend to show a larger rate of complications than do those that draw primarily from clinics, such as the Cleland study[58] cited by Dr. Grossman.

42. It is difficult to see how telemedicine could do anything but exacerbate this issue, as it weakens the link between women and their physicians even more. For verification of this, we can look to Dr. Grossman, who published a paper indicating that women who had

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[55] *See id.* at 6-7.
[56] Grossman Affidavit at 12.
[57] Attachment I, Upadhyaha at 175.
[58] K. Cleland et al., *Significant adverse events and outcomes after medical abortion,* 121 J. OBSTET. GYNECOL., 166-71 (2013).

telemedicine abortions were less likely to follow up with the abortion provider.[59] "It is possible," Dr. Grossman and his co-authors conceded, "that meeting with a clinician virtually rather than in person may reduce one's likelihood to return for a follow-up visit."[60]

43. Telemedicine abortion is touted as being particularly helpful to rural areas, but that leads to a serious question. According to FDA records, many of the first 600 severe adverse event reports in the first four years after mifepristone approval in 2000 would have been fatalities except for prompt access to emergency intervention and adequate hospital access.[61] Here, though, Plaintiffs want to use telemedicine to initiate a procedure that commonly results in hemorrhage, ER visits, need for emergency surgery, transfusions, etc., in precisely those areas of Oklahoma where emergency services are the least accessible. This places the women in remote areas of Oklahoma at the highest risk of turning a manageable complication into something far worse. Presumably for this reason, the ACOG Practice Bulletin on Medical Management of Abortion—authored by Dr. Grossman—says women are poor candidates for medical abortion if they are not able to follow up.[62]

III. Responses and Critiques

44. Plaintiffs argue that "Telemedicine is now widespread in Oklahoma and used to deliver a broad range of healthcare services, including addiction treatment, chronic disease management, high-risk pregnancy, oncology, radiology, and stroke treatments."[63] Though I cannot speak to Oklahoma law or practice more broadly, I am aware that Oklahoma limits the use of telemedicine in at least one area—that of opioids.[64] Moreover, none of the services listed by Plaintiffs is obviously comparable to the administration of a medication abortion. Rather, the majority of these and other telemedicine services are likely to be conversation- or consultation-based, not procedure-based. None of the services listed here are either elective procedures, such as elective abortion, nor are they surgical services. None involve starting an invasive procedure such as a mifepristone abortion in clinical situations that do not have adequate medical infrastructure to handle known complications.

45. Plaintiffs cite several studies by Dr. Grossman to claim that telemedicine abortions are just as safe as regular medical abortions. But the protocols Dr. Grossman describes in these studies do not appear to include physical examination. Indeed, one of the studies even states that a "physical examination was not routinely done, consistent with the standard of care."[65] Because neither the in-person protocol nor the telemedicine protocol includes a physical examination which in my opinion is essential to ruling out contraindications

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[59] *See* J.E. Kohn, D. Grossman, et al., *Medication Abortion Provided Through Telemedicine in Four U.S. States*, 00 J. OBSTET. GYNECOL., 1-8 (2019), provided as Attachment N.
[60] *Id.* at 6.
[61] *See* Attachment H, Gary.
[62] Attachment L, ACOG Practice Bulletin at 6.
[63] Plaintiffs' Memorandum at 5.
[64] *See* Okla. Stat. tit. 59 § 478(c) (2017).
[65] D. Grossman et al., *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*, 118 J. OBSTET. GYNECOL. No. 2, Part 1 at 297 (2011), provided as Attachment O.

prior to administering Mifeprex, it is not particularly surprising that the studies show little difference between groups—in them, women were receiving less care than they deserve. Moreover, in the most recent study there was much less follow-up with patients who had received telemedicine abortions.[66] And it defined "significant" adverse events much in the same way that Dr. Grossman defined "major" complications above—*i.e.*, very narrowly, to exclude some emergency room visits, hemorrhaging, and surgical abortions.[67]

46. Plaintiffs claim that medical abortion "is non-invasive."[68] This label is itself concerning. Mifepristone interferes with the natural physiological process of pregnancy, to result in the death of a separate human being, and it leads to the painful expulsion of that human being and placenta from inside the woman's body. And, again, the risks associated with this procedure are greater than the risks associated with surgical abortion, and they include infection, hemorrhage, and follow-up surgical abortions.

47. Plaintiffs also claim to have used telemedicine safely in other states,[69] but Plaintiffs provide zero data to back that claim. They further argue that "In fact, in 2018, Trust Women Oklahoma City performed 664 medication abortions without a single reportable complication or adverse event."[70] However, Plaintiffs do not provide any evidence for this, quite frankly, unbelievable claim. Did they have 100% follow up for each patient? Do they have an electronic medical record which interdigitates with all local hospitals so that they would know about complications? When they say "reportable claim" are they referring to the new 2016 FDA requirement to report only deaths? In all likelihood, what Trust Women Oklahoma is really saying is that none of the 664 medication abortion patients came back to them for management of the 3-5% known complications and ER visits resulting from initiation of medication abortion. That is not a good thing.

48. In my experience as a woman and as a surgeon who has cared for women prior to surgery, women expect that they will have appropriate pre-procedure medical care prior to initiating a procedure, including a medical abortion. It is surgical standard of care that the surgeon takes a history, does a physical examination and discusses not only the diagnosis, but also the risks and alternatives with a patient prior to any procedure. For a non-emergency surgery such as an elective abortion, it is standard of care for a woman to have some time to consider what the physician has communicated to her without pressure to complete a procedural path which has already been initiated. That's what women expect from medical care. And that is not provided by the telemedicine protocol given by the Plaintiffs.

AFFIANT FURTHER SAYETH NOT.

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[66] Attachment N, Kohn at 1.
[67] Attachment N, Kohn at 4.
[68] Plaintiffs' Memorandum at 4.
[69] Plaintiffs' Memorandum at 11.
[70] Burkhart Affidavit at 5.

I state under penalty of perjury under the laws of Oklahoma that the foregoing is true and correct.

Date: January 03, 2020
Eau Claire, MI

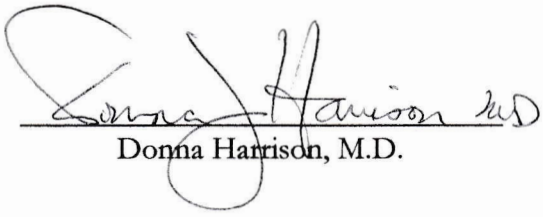
By: 
Donna Harrison, M.D.

Exhibit 8

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

SOUTH WIND WOMEN'S CENTER LLC, *et al.*, *Plaintiffs,* v. J. KEVIN STITT, *et al.*, *Defendants,*	No. 20-cv-277-G

DECLARATION OF RITA SANDERS, D.O.

I, Rita Sanders, D.O., declare the following:

1. I am an osteopathic physician (D.O.). I graduated from the Western University of Health Sciences in 1990, and completed my residency at University of Oklahoma College of Medicine, Tulsa. I am licensed in Oklahoma, Arkansas, and California. I am a member of Oklahoma Osteopathic Association.
2. I am an OBGYN, board-certified by the American College of Obstetricians and Gynecologists (ACOG). I am also a member of the American Board of Obstetrics and Gynecology (ABOG) and the American Association of Pro-life Obstetricians and Gynecologists (AAPLOG).
3. At present, I am an obstetrics (OB) hospitalist at a hospital in Arkansas. I work in a hospital with a dedicated OB emergency room, which encompasses all aspects of OB emergencies, deliveries, C-sections, as well as routine OB care. This includes occasionally handling post-abortion patients with complications.
4. Up until about two years ago, I ran my own private OBGYN practice in Oklahoma. I performed about 150 deliveries a year, and delivered over 3,000 babies over the course of

nearly 20 years. I focused on pregnancy care, well-woman gynecology, and gynecologic surgery. During that time, a number of women came to my private practice that had undergone abortions, surgical and medical, and would come in bleeding the next day and have to be admitted for repeat procedures and blood transfusions. For medical abortions, in particular, some of them will bleed heavily afterwards and wind up in the emergency room or a doctor's office.

5. During a pandemic like the one we are experiencing, medical surgeries—abortion and otherwise—should require the extensive use of personal protective equipment (PPE). Anyone who suggests otherwise is potentially being negligent. They are exposing themselves as well as their assistants to potential infection more than they should. Any actual surgeries taking place right now should be using full and in some cases extra PPE materials. Everyone that walks in an out of any room must consider wearing a mask and other gear.

6. I disagree with the abortion clinics suing here saying that Governor Stitt's order postponing all elective surgeries will increase the need for PPE and hospital beds to deal with prenatal care. That's just not true, at least not immediately. Pregnancy services can and are being postponed and many are being offered through telemedicine unless the patient is very high risk. Anything non-essential can be done through telemedicine, facetime, skype or over the phone: Women can weigh themselves, get directed to a lab with a doctor's electronic order, and many of them can even take their own blood pressure. My daughter-in-law in San Francisco is pregnant, and has experienced this first-hand as she has received prenatal care from the comfort of her home. Moreover, PPE that might be used in the future at childbirth is a number of months away. The immediate is what matters for this pandemic. We are in the now, not in the future.

7. In the emergency room where I work, we are in desperate need of more PPE. I am wearing the same mask for my 24 hour shift because of the pandemic. To cope, some of the volunteers have made cloth masks, and we are putting cloth masks over our regular masks. These are being used in conjunction with the regular mask and not as a substitute.

8. Moreover, what do the clinics do if they have a complication? Abortions do have complications—I have seen them, both in private practice and as an OB emergency physician. Complications might require hospital space, which is dwindling as we speak.

9. In my view, the elective surgery and procedure postponement is necessary, for now. This is an international pandemic, and within reason combating it must take precedence over individual concerns. Everyone is suffering harm from the primary effect. No one, including pregnant women, should be traveling, or undergoing procedures that could over-burden the healthcare system or deprive it of vital resources. We are temporarily redirecting materials to save lives. What is certain is that the permanent negative irreparable harm will be much worse the longer it takes to complete the primary effort. It is a tough situation.

I state under penalty of perjury that the foregoing is true and correct to the best of my knowledge. Executed this 2nd day of April, 2020 in Tulsa, Oklahoma.

s/ *Rita Sanders,* D.O.*

Rita Sanders, D.O.

* Pursuant to *ECF Policies and Procedures Manual*, § II(C)(3)(a)(i), I certify the signed original of this document is being sent to counsel for Defendants. It will be maintained and available for inspection at any time by the Court or a party to this action once received.

s/ *Mithun Mansinghani*

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