STATE OF MICHIGAN
IN THE SUPREME COURT

GRETCHEN WHITMER, on behalf of the State of Michigan,

Plaintiff,

v

Supreme Court No. 164256

Oakland Circuit Court No. 22-193498-CZ

Hon. Edward Sosnick

JAMES R. LINDERMAN, Prosecuting Attorney of Emmet County, DAVID S. LEYTON, Prosecuting Attorney of Genesee County, NOELLE R. MOEGGENBERG, Prosecuting Attorney of Ingham County, JERARD M. JARZYNKA, Prosecuting Attorney of Jackson County, JEFFREY S. GETTING, Prosecuting Attorney of Kalamazoo County, CHRISTOPHER R. BECKER, Prosecuting Attorney of Kent County, PETER J. LUCIDO, Prosecuting Attorney of Macomb County, MATTHEW J. WEISE, Prosecuting Attorney of Marquette County, KAREN D. McDONALD, Prosecuting Attorney of Oakland County, JOHN A. McCOLGAN, Prosecuting Attorney of Saginaw County, ELI NOAM SAVIT, Prosecuting Attorney of Washtenaw County, and KYM WORTHY, Prosecuting Attorney of Wayne County, in their official capacities,

Defendants.

MOTION OF PLANNED PARENTHOOD OF MICHIGAN & SARAH WALLETT, M.D., M.P.H., FACOG, FOR LEAVE TO FILE AMICUS CURIAE BRIEF

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**Appearing under MSC IOP 7.311(A)(2)(b)*
***Student attorney practicing pursuant to MCR 8.120*

Attorneys for Planned Parenthood of Michigan & Sarah Wallett, M.D., M.P.H., FACOG

DATED: June 8, 2022

NOW COME Planned Parenthood of Michigan and Sarah Wallett, M.D., M.P.H., FACOG, and respectfully move this Honorable Court for leave to file the attached *amici curiae* brief, pursuant to MCR 7.312(H) and this Court's Order of May 20, 2022, *In re Executive Message of Governor*. In support of this motion, Planned Parenthood of Michigan and Sarah Wallett, M.D., M.P.H., FACOG, state as follows:

1. Proposed *amici curiae*, Planned Parenthood of Michigan ("PPMI") and Sarah Wallett, M.D., M.P.H., FACOG (together, "Amici"), are Plaintiffs in the matter of *Planned Parenthood of Michigan & Sarah Wallett, M.D., M.P.H., FACOG v Attorney General of the State of Michigan*, Case No. 22-000044-MM (Court of Claims, Gleicher, J.). Amici seek permission to submit an *amicus curiae* brief to address two questions posed by this Court's order of May 20, 2022, specifically:

> (1) Whether the Court of Claims' grant of a preliminary injunction in *Planned Parenthood v Attorney General*, 22-000044-MM, resolves any need for this Court to direct the Oakland County Circuit Court to certify the questions posed for immediate determination; and
>
> (5) Whether the questions posed should be answered before the United States Supreme Court issues its decision in *Dobbs v Jackson Women's Health Organization*, No. 19-1392, and whether a decision in that case would serve as binding or persuasive authority to the questions raised here.

2. PPMI, which itself or through its predecessors has been in operation for at least the last one hundred years, is a not-for-profit corporation operating 14 health centers in Michigan, with headquarters in Ann Arbor. PPMI's mission is to promote healthy communities and the right of all individuals to manage their sexual health by providing health care and education and serving as a strong advocate for reproductive justice. PPMI's health centers provide a wide range of reproductive and sexual health services to patients, including testing and treatment for sexually transmitted infections (STIs); contraception counseling and provision, including provision of long-

acting reversible contraceptive (LARC) devices; HIV prevention services; pregnancy testing and options counseling; preconception counseling; gynecologic services including menopause care; well-person exams; cervical cancer screening; treatment of abnormal cervical cells; breast cancer screening; colposcopy; miscarriage management, and abortion. PPMI faces possible criminal prosecution, licensure penalties, and other civil enforcement actions for providing abortions in violation of MCL 750.14 (the "Criminal Abortion Ban") as written, and therefore brought suit on its own behalf, on behalf of its physicians and staff, and on behalf of its patients, who are at imminent risk of losing access to abortion in violation of their constitutional rights, absent a continued injunction barring enforcement of the Criminal Abortion Ban, or until declaration of the right to abortion under Michigan's Constitution.

3. Plaintiff Sarah Wallett, M.D., M.P.H., FACOG is a board-certified obstetrician-gynecologist (OB/GYN) licensed to practice medicine in Michigan. She is a resident of the state of Michigan. Dr. Wallett has been the Chief Medical Officer of PPMI since March 2019. Dr. Wallett is also an adjunct clinical professor at the University of Michigan Medical School in Ann Arbor. Dr. Wallett has provided abortion since 2009. For providing abortions in violation of the Criminal Abortion Ban as written, Dr. Wallett faces possible felony criminal prosecution and licensure penalties. Dr. Wallett filed suit on her own behalf and on behalf of her patients, who are at imminent risk of losing access to abortion in violation of their constitutional rights, absent a continued injunction of the Criminal Abortion Ban, or until declaration of the right to abortion under Michigan's Constitution.

4. As set forth in the proposed *amici curiae* brief, Amici address questions 1 and 5 posed by this Court's May 20, 2022 Order, from the perspective of Amici who are actively

litigating these issues in the Court of Claims and are particularly aware of the need for prompt review to resolve the questions identified by the Executive Message of Governor.

WHEREFORE Planned Parenthood of Michigan and Sarah Wallett, M.D., M.P.H., FACOG, respectfully request that this Honorable Court grant their request to participate as *amici curiae* in this case and accept the attached proposed brief for filing.

Respectfully submitted,

/s/ Deborah LaBelle

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DATED: June 8, 2022

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Defendants.

BRIEF OF PLANNED PARENTHOOD OF MICHIGAN & SARAH WALLETT, M.D., M.P.H., FACOG, AS AMICI CURIAE IN SUPPORT OF GOVERNOR'S EXECUTIVE MESSAGE

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DATED: June 8 , 2022

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INTRODUCTION

Amici Curiae Planned Parenthood of Michigan and Sarah Wallett, M.D., M.P.H., FACOG (Planned Parenthood, or Amici) are plaintiffs in *Planned Parenthood of Michigan v Attorney General of the State of Michigan*, Case No. 22-000044-MM (Court of Claims, Gleicher, J.), and submit this amici curiae brief in support of Governor Whitmer's request for prompt declaration of the right to an abortion under the 1963 Michigan Constitution, and to address two of the five questions posed by this Court's order of May 20, 2022:

> (1) Whether the Court of Claims' grant of a preliminary injunction in *Planned Parenthood v Attorney General*, 22-000044-MM, resolves any need for this Court to direct the Oakland Circuit Court to certify the questions posed for immediate determination[, and]
>
> (5) Whether the questions posed should be answered before the United States Supreme Court issues its decision in *Dobbs v Jackson Women's Health Organization*, No. 19-1392, and whether a decision in that case would serve as binding or persuasive authority to the questions raised here.[1]

ARGUMENT

I. The Court of Claims' grant of a preliminary injunction in *Planned Parenthood of Michigan v Attorney General* does not obviate the need for this Court to promptly address the issues presented by the Governor's Executive Message.

The Court of Claims' grant of a preliminary injunction in *Planned Parenthood of Michigan v Attorney General* does not resolve the need for this Court to promptly address questions posed by the Governor's Executive Message. Both this case and *Planned Parenthood of Michigan v Attorney General* seek a declaration that MCL 750.14 (the "Criminal Abortion Ban") violates

[1] Pursuant to MCR 7.312(H)(4), counsel for amici have authored this brief in whole. Neither counsel nor any party to this matter have made any monetary contributions intended to fund the preparation or submission of this brief, nor has any other person other than amici, its members or counsel made any such contributions including any monetary contributions.

multiple provisions of the Michigan Constitution, including the Due Process Clause and the Equal Protection Clause. The Court of Claims' preliminary injunction is not a final resolution of those questions. Particularly because the fundamental-rights issues raised in both cases will most assuredly come before this Court, it is prudent for this Court to take up the issue as quickly as possible.

The injunction entered by Judge Gleicher, while preliminary, should nonetheless be viewed as neither tenuous nor fragile, but rather well grounded in law and the recognition of the irreparable harm that would occur absent its issuance. Despite the recent filing of a complaint for superintending control by nonparty entities (two organizational plaintiffs and two prosecuting attorneys) as a collateral attack on the Court of Claims' preliminary injunction in *Planned Parenthood of Michigan v Attorney General,* that action poses no risk to the preliminary injunction. The complaint in that action has zero merit, as set forth in Amici's forthcoming answer, to be filed by June 13, 2022, and which Amici will file in a supplemental attachment to this Court.[2]

Further, while the Governor raises a concern that the Court of Claims' opinion granting injunctive relief may not be binding on other Michigan trial courts, such a concern is not relevant given the scope of the injunction entered and the parties bound thereby. The preliminary injunction was entered against the top law enforcement officer of this state, the Attorney General, and through her it binds all state agents, officers, and entities, including those under her supervision. See MCL 14.30. Should any of these state actors attempt to enforce the Criminal Abortion Ban, they can be

[2] The central argument of the complainants in the superintending control filing, was that the Court of Claims lacked jurisdiction due to the defendant Attorney General's public support for abortion rights in Michigan and the lack of any other defendant. The complainants argued that the parties must have sufficient diverse positions on the merits in order for the Court of Claims to have jurisdiction. And while PPMI argued, and the court held, the law to be otherwise, on June 6, 2022, the Michigan House of Representatives and Michigan Senate filed a motion to intervene as defendants in *Planned Parenthood of Michigan v Attorney General*.

held in contempt of the injunction in the Court of Claims, no matter what trial court they bring their enforcement action in. It is therefore irrelevant whether other trial courts disagree with the reasoning or conclusion of the Court of Claims' opinion, as there is no scenario where they could nullify that court's injunction. In other words, the injunction is binding statewide not because that court's opinion creates legal precedent for other courts, but because it binds—through the Attorney General—the state and its agents. Thus, what another trial court says about the basis for the injunction does not in any way diminish the power or effect of the Court of Claims' injunctive order.

The binding effect of the injunction precludes all prosecutions under state law. Under Michigan law, a litigant need not sue the prosecuting attorneys of all 83 counties to ensure that an unconstitutional law will not be enforced. Instead, because Michigan law provides that the Attorney General "shall supervise the work of . . . the prosecuting attorneys, in all matters pertaining to the duties of their offices," MCL 14.30, a judgment against the Attorney General regarding the enforceability of a state criminal law is binding on county prosecutors. A county prosecutor, although elected at the local level, "act[s] as a state agent when prosecuting state criminal charges." *Cady v Arenac Co*, 574 F3d 334, 343 (CA 6, 2009) (citations omitted); see also *id*. at 345. Indeed, the case captions in all such prosecutions state that the named-party plaintiff is the People of the State of Michigan. Prosecutors acting in the name of the people of this state are bound by judgments against the state official who supervises them.

The United States Court of Appeals for the Sixth Circuit confirmed the binding effect of injunctions regarding state criminal laws in *Platinum Sports Ltd v Snyder*, 715 F3d 615 (CA 6, 2013). The plaintiff in *Platinum Sports* filed a lawsuit to enjoin enforcement of a Michigan law that had already been enjoined in a previous lawsuit brought by a different set of plaintiffs. *Id*. at

616. The Sixth Circuit explained that the new plaintiff could not obtain additional relief because local prosecutors were bound by the permanent injunction against state officials that was already in place:

> The "executive power" of Michigan is "vested in the governor," Mich. Const. art. V, § 1, and the Attorney General, as the top legal official in the State, is bound by a permanent injunction against his top client: the Governor. As for local prosecutors, they answer to the Attorney General, who is obligated to "supervise the work of . . . prosecuting attorneys."[MCL] 14.30. Any effort by a prosecutor at this point to enforce the statutes—keeping in mind that no one has threatened any such thing—would be *ultra vires*. [*Id*. at 619 (omission in original).]

The existence of a fully intact preliminary injunction in *Planned Parenthood of Michigan v Attorney General* does not, however, undercut the need for this Court to exercise its authority to review the questions presented by both the Governor's request for certification and by *Planned Parenthood of Michigan v Attorney General*. There continues to be a need for this Court to address the question presented by these cases: whether the Michigan Constitution protects the right to abortion in this state. The preliminary injunction ensures that people will not be abruptly deprived of access to abortion in Michigan if the United States Supreme Court eliminates the federal right while this Court decides the state constitutional questions presented, but it does not reduce the urgency of the need for the Court to resolve those questions once and for all.

II. The questions posed in this case should be answered before the United States Supreme Court issues its decision in *Dobbs v Jackson Women's Health Organization*, as a decision in that case would not be binding or persuasive authority to the questions raised here.

The United States Supreme Court's decision in *Dobbs v Jackson Women's Health Organization* will not bind this Court or change its legal analysis interpreting the Michigan Constitution. The parallel constitutional questions presented by the Governor in this case and by Amici in their case are ripe for this Court's consideration and require prompt resolution.

Whether the Criminal Abortion Ban violates the Michigan Constitution "is not dependent on any determination by" the United States Supreme Court. See *Citizens Protecting Michigan's Constitution v Secretary of State*, 280 Mich App 273, 283; 761 NW2d 210 (2008), aff'd in part, lv den in part 482 Mich 960 (2008). This Court "alone is the ultimate authority with regard to the meaning and application of Michigan law." *People v Bullock*, 440 Mich 15, 27; 485 NW2d 866 (1992). As such, Michigan courts can "interpret the Michigan Constitution more expansively than the United States Constitution." *Id.* at 28; see also *id.* at 29 n 9 (listing examples); see also *People v Vaughn*, 491 Mich 642, 650 n 25; 821 NW2d 288 (2012).

In *Mahaffey v Attorney General*, the Court of Appeals observed that "the existence of a federal constitutional right to abortion is not necessarily relevant to [the] determination" whether a state constitutional right to abortion exists. 222 Mich App 325, 333–334; 564 NW2d 104 (1997) (citation omitted). Quoting *Sitz v Department of State Police*, 443 Mich 744, 761–762; 506 NW2d 209 (1993), the Court of Appeals in *Mahaffey* explained: "[a]ppropriate analysis of our constitution does not begin from the conclusive premise of a federal floor. . . . As a matter of simple logic, because the texts were written at different times by different people, the protections afforded may be greater, lesser, or the same." *Mahaffey*, 222 Mich App at 334 (omission in original).

Since Michigan's constitution stands independent of the federal constitution, Michigan courts are not bound by the contours of federal constitutional doctrine in applying any given state constitutional guarantee. See *Glover v Mich Parole Bd*, 460 Mich 511, 522; 596 NW2d 598 (1999); *Bauserman v Unemployment Ins Agency*, 503 Mich 169, 185 n 12; 931 NW2d 539 (2019); *Gilmore v Parole Bd*, 247 Mich App 205, 222; 635 NW2d 345 (2001); *Sitz v Dept of State Police*, 443 Mich 744, 761–762; 506 NW2d 209 (1993). Michigan courts are "free to find that an individual has greater rights under a Michigan constitutional provision than under its federal counterpart when

compelling reasons to do so exist," *Glover*, 460 Mich at 522, "even where the language is identical," *People v Goldston*, 470 Mich 523, 534; 682 NW2d 479 (2004). Further, "'compelling reason' should not be understood as establishing a conclusive presumption artificially linking state constitutional interpretation to federal law." *Sitz*, 443 Mich at 758. As the Court explained in *Sitz*:

> [T]he courts of this state should reject unprincipled creation of state constitutional rights that exceed their federal counterparts. On the other hand, our courts are not obligated to accept what we deem to be a major contraction of citizen protections under our constitution simply because the United States Supreme Court has chosen to do so. We are obligated to interpret our own organic instrument of government. [*Id.* at 763 (emphasis added).]

This Court need not and should not await an opinion from the United States Supreme Court addressing a federal constitutional issue before it addresses the separate and distinct issue of the Criminal Abortion Ban's illegality under the Michigan Constitution.

Indeed, the constitutional questions raised in both the Governor's suit and Planned Parenthood's suit are fully ripe for review, regardless of the outcome in *Dobbs*. Both cases seek declaratory relief establishing the Michigan Constitution's independent protection of the right to abortion. Suits for declaratory relief under MCR 2.605(A)(1) are ripe when the requested declaration "is needed to guide a [plaintiff]'s future conduct in order to preserve that [plaintiff]'s legal rights." *League of Women Voters of Mich v Secretary of State*, 506 Mich 561, 586; 957 NW2d 731 (2020), citing *UAW v Cent Mich Univ Trustees*, 295 Mich App 486, 495; 815 NW2d 132 (2012). State constitutional claims are ripe for determination where those claims ask for a "threshold determination" of law not requiring any factual development, even though it is possible that future events could moot the claims, so long as those future events would not affect the legal analysis. See *Mich United Conservation Clubs v Secretary of State*, 463 Mich 1009; 625 NW2d 377 (2001) (mem); *Citizens Protecting Michigan's Constitution*, 280 Mich App at 282–283.

Because the outcome in *Dobbs* will not change the Michigan Constitution, this Court can address the substance and application of those state constitutional protections today. Furthermore, in determining whether this Court should await a ruling in *Dobbs*, the Court should consider the harm being caused by the uncertainty of whether state constitutional rights will protect abortion providers and patients in Michigan should *Dobbs* overrule or modify the federal constitutional right to abortion. The Court should also consider the importance of its independent evaluation of the Michigan Constitution and a recognition of Michigan citizens' rights, irrespective of how the United States Supreme Court changes the interpretation of the federal constitution. For both reasons, there is little value in awaiting the ruling in *Dobbs*.

As addressed above, the Michigan Constitution has its own language and etiology, and an independent review of its protections of basic rights for Michigan citizens is necessary given the irreparable harm that Amici and their patients would face absent permanent declaratory and injunctive relief under the Michigan Constitution. And, while the existence of the injunctive relief granted in *Planned Parenthood of Michigan v Attorney General* has tempered the anxiety and uncertainty, the uncertainty will not be fully resolved, as detailed in Dr. Wallett's affidavit, until this Court addresses the constitutional right to abortion under the Michigan Constitution. See Wallett Affidavit in Support of Plaintiffs' April 7, 2022 Motion for Preliminary Injunction in *Planned Parenthood of Michigan v Attorney General*, attached hereto as Exhibit 1.

Amici sought and obtained preliminary injunctive relief to maintain the status quo while the courts decide the constitutional questions presented. It is ultimately for this Court to resolve those questions. If the Criminal Abortion Ban is not declared unconstitutional and permanently enjoined, Amici and others face legal uncertainty without protection from investigations,

prosecutions, and administrative penalties for providing constitutionally protected abortions, and their patients face a risk of irreparable injury from the violation of their constitutional rights.

CONCLUSION

The Court should grant the Governor's request for prompt declaration of the right to an abortion under the 1963 Michigan Constitution. Whatever the vehicle for this Court's review, the mechanism is less important than the legal questions presented here and the need to avert widespread irreparable harm through permanent declaratory and injunctive relief. This Court has never considered or ruled on the existence of a state constitutional right to abortion, largely in reliance on almost fifty years of federal protections under the United States Constitution. But those federal protections are disappearing and the Court must promptly address the state constitutional questions now. Whether the matter is decided by this Court after a Court of Claims decision on Amici's request for a permanent injunction and declaratory relief through a motion for summary disposition, or whether this Court agrees to direct the trial courts to certify the issue for immediate review, the Court must recognize the existence of a state constitutional right to abortion, and the status quo—access to safe, legal abortion in Michigan—must be preserved until the Court does so.

Respectfully submitted,

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DATED: June 8, 2022

EXHIBIT 1

STATE OF MICHIGAN
IN THE COURT OF CLAIMS

PLANNED PARENTHOOD OF MICHIGAN, on behalf of itself, its physicians and staff, and its patients; and **SARAH WALLETT, M.D., M.P.H., FACOG**, on her own behalf and on behalf of her patients,

Plaintiffs,

v

ATTORNEY GENERAL OF THE STATE OF MICHIGAN, in her official capacity,

Defendant.
_____/

Case No.

Hon.

AFFIDAVIT OF SARAH WALLETT, M.D., M.P.H., FACOG, IN SUPPORT OF PLAINTIFFS' APRIL 7, 2022 MOTION FOR PRELIMINARY INJUNCTION

I, Sarah Wallett, M.D., M.P.H., FACOG, being duly sworn on oath, do depose and state as follows:

1. I am a board-certified obstetrician-gynecologist licensed in Michigan and the Chief Medical Officer of Planned Parenthood of Michigan (PPMI). Along with PPMI, I am a plaintiff in this case.

2. I went to medical school because I was raised to understand that it was my duty to help people in need. In service of that duty, I began providing abortion to patients in Michigan in 2009, and I continue to do so today. This medical care is life-changing and, in many circumstances, life-saving. Indeed, I believe that providing abortion is the most important thing I will ever do.

3. I understand that a 1931 Michigan statute bans abortion, even in cases of rape, incest, or grave threats to the pregnant person's health. I understand that if this law (the "Criminal Abortion Ban") were enforced as written, I could be criminally prosecuted for providing an

abortion at any point in pregnancy, unless the abortion is necessary to save the pregnant person's life. I understand that the Michigan Supreme Court has said that I cannot be prosecuted for providing pre-viability abortion, but if the Criminal Abortion Ban can be enforced as written, I believe I am at risk of possible prosecution—and at risk of losing my medical license—if I continue to provide abortion to my patients.

4. I understand that the Michigan Supreme Court has discussed this law before and ruled that physicians cannot be prosecuted under the Criminal Abortion Ban because the federal constitution protects the right to choose to terminate a pregnancy, as recognized in *Roe v Wade*. This interpretation is what allows me to provide abortion in Michigan today. But should the United States Supreme Court modify those federal protections—which I understand it may do any day now, in the *Dobbs v Jackson Women's Health Organization* case—the Michigan Supreme Court's decision may no longer protect physicians like me from felony prosecution under the Criminal Abortion Ban.

5. My patients' lives and my own would be profoundly disrupted if the Criminal Abortion Ban were enforced to criminalize abortion in Michigan. So would the lives of other Michigan physicians who provide abortion, and of the staff who assist us in doing so. Accordingly, I submit this affidavit in support of the motion for a preliminary injunction to preserve my patients' access to this essential health care and to protect PPMI, myself, and physicians like me from felony prosecution and other civil and administrative penalties.

6. The facts I state here and the opinions I offer are based on my education, my training, my years of medical practice, my expertise as a doctor and specifically as an abortion provider, my personal knowledge, information obtained through the course of my duties at PPMI, and my familiarity with relevant medical literature and statistical data recognized as reliable in the medical profession.

My Education and Professional Background

7. I graduated from Jefferson Medical College (which has since been renamed Sidney Kimmel Medical College) at Thomas Jefferson University in 2009 and completed my residency in obstetrics and gynecology (OB/GYN) at the University of Michigan Medical School in 2013. After residency, I completed a two-year fellowship in complex family planning at the University of Michigan Medical School. While pursuing this fellowship, I also obtained a Master of Public Health degree from the University of Michigan, focusing specifically on health policy.

8. Following my fellowship, I worked as a professor at the University of Kentucky during the 2015–16 term. I then served as Medical Director at Planned Parenthood of the Greater Memphis Region. When that affiliate merged with another to become Planned Parenthood of Tennessee and North Mississippi, I became the Chief Medical Officer of the newly merged affiliate.

9. I became Chief Medical Officer at PPMI, my current role, in March 2019. I also currently serve as an adjunct clinical assistant professor at the University of Michigan Medical School, training University of Michigan medical students, OB/GYN residents, family medicine residents, family medicine fellows, and OB/GYN fellows on site at PPMI's health centers. Finally, I am the current president of the council of Planned Parenthood affiliate medical directors, which supports medical directors in ensuring high-quality clinical care at Planned Parenthood health centers nationwide.

10. A copy of my *curriculum vitae* is attached as Exhibit A.

Planned Parenthood of Michigan

11. PPMI is a not-for-profit corporation headquartered in Ann Arbor that currently operates 14 health centers across Michigan, in Ann Arbor, Detroit, Ferndale, Flint, Grand Rapids, Jackson, Kalamazoo, Lansing, Livonia, Marquette, Petoskey, Traverse City, and Warren. PPMI or

its predecessors have been operating in Michigan since at least 1922. PPMI is not the only abortion provider in the state; I know that other physicians and hospitals also provide medication abortion and procedural abortion in Michigan.

12. PPMI's health centers provide a wide range of reproductive and sexual health services to patients, including testing and treatment for sexually transmitted infections (STIs), contraception counseling and provision including provision of long-acting reversible contraceptive (LARC) devices, HIV prevention services, pregnancy testing and options counseling, preconception counseling, gynecologic services including menopause care, well-person exams, cervical cancer screening, treatment of abnormal cervical cells, breast cancer screening, colposcopy, miscarriage management, and abortion.

13. PPMI's health centers provide medication abortion through 11 weeks, or 77 days, from the first day of the pregnant person's last menstrual period (LMP). Additionally, PPMI's Ann Arbor East and Kalamazoo health centers provide procedural abortion through 19 weeks, 6 days LMP, and our Flint health center provides procedural abortion through 16 weeks, 6 days LMP. Each of these three health centers is licensed as a Freestanding Outpatient Surgical Facility by the Michigan Department of Licensing and Regulatory Affairs. In Fiscal Year 2020 (October 2019 through September 2020), PPMI provided 8,448 abortions. Of those, 6,626 were medication abortions, and 1,822 were procedural abortions.

14. Michigan law creates multiple obstacles that patients must navigate to access abortion here. For example, patients must receive state-mandated information designed to deter them from deciding to have an abortion, then wait 24 hours before initiating their abortion.[1] Minor patients must obtain either written parental consent or permission from a judge before having an

[1] See MCL 333.17015(3).

abortion.[2] And private insurance and insurance obtained through the health care exchanges under the Affordable Care Act can only cover abortion if the patient's life is endangered (or, for private insurance, if a rider was purchased).[3] As an abortion provider in Michigan, I comply with these requirements because they are mandated by law, but none of the requirements is medically necessary or does anything to make my patients healthier or safer.

15. PPMI employs full-time physicians and part-time physicians, as well as physicians who perform contracted work through arrangements with teaching hospitals and universities. All physicians employed by PPMI currently have admitting privileges at the University of Michigan Hospital in Ann Arbor.

16. As Chief Medical Officer at PPMI, I have clinical, administrative, and managerial responsibilities. On the clinical side, as discussed in more detail below, I provide patients with both medication abortion and procedural abortion. I also provide contraception and contraceptive counseling, STI screening and treatment, and miscarriage management. When a patient presents with a complex contraceptive case or requires certain gynecological procedures such as colposcopy, I provide that care as well.

17. I see abortion patients from Michigan as well as abortion patients who travel to Michigan from other states. Between July 2020 and June 2021, PPMI saw 615 abortion patients who traveled to our health centers from other states—7% of the total number of abortion patients seen in that time period. By comparison, in that same time frame, 3% of the patients PPMI saw for all health care services (including abortion) came from out of state.

18. In addition to caring for patients, as Chief Medical Officer I oversee all clinical care and operations at PPMI. This entails supervising more than 10 physicians; more than 20 clinicians;

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[2] MCL 722.903–722.904.
[3] MCL 550.541–550.551.

licensed and non-licensed health center staff; and a rotating set of medical students, residents, and fellows who come to PPMI to complete training in abortion and other health care. I also oversee staff's training, proctoring, and annual assessments of their clinical skills.

Pregnancy Has Significant Medical, Financial, and Personal Consequences

19. To understand why abortion matters, it is important first to understand all the ways in which pregnancy affects a person, both during the pregnancy itself and for years afterward.

20. People experience their pregnancies in a range of different ways. While pregnancy can be a celebratory and joyful event for many families, even an uncomplicated pregnancy challenges a person's entire physiology and stresses most major organs. Pregnancy can also be a period of physical and personal discomfort or even alienation; some pregnant people experience significant mental health challenges. For some, such as pregnant people who are transmasculine, nonbinary, or gender-nonconforming, pregnancy can cause dysphoria, a state of unease or general dissatisfaction with life.

21. Pregnancy and childbirth carry significant medical risk. Maternal mortality is a serious problem in the United States. Although most maternal deaths are preventable, maternal mortality rates in this country are rising.[4] The risk of death associated with childbirth is estimated to be 8.8 deaths per 100,000 live births, and the overall risk of maternal mortality[5] is estimated to

[4] Commonwealth Fund, *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries* (2020), available at <https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries>.

[5] As used in this statistic, "maternal mortality" refers to "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes." Hoyert, *Maternal Mortality Rates in the United States, 2020*, Ctrs for Disease Control & Prevention (CDC), Nat'l Ctr for Health Statistics, Div of Vital Statistics (2022), p 1, available at <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/E-stat-Maternal-Mortality-Rates-2022.pdf>.

be 23.8 deaths per 100,000 live births.[6] For comparison, less than one woman dies for every 100,000 abortion procedures.[7]

22. Women of color, and Black women in particular, face heightened risks of maternal mortality and pregnancy-related complications compared to non-Hispanic white women.[8] This disparity between the maternal mortality rates for women of color and non-Hispanic white women has been exacerbated in the past year.[9] Specifically, recent research found that the maternal mortality rate among non-Hispanic Black women was 3.55 times that of non-Hispanic white women, a dramatic increase from previous analysis.[10] Postpartum cardiomyopathy, preeclampsia, and eclampsia were leading causes of maternal death for non-Hispanic Black women, with mortality rates five times those of non-Hispanic white women with the same conditions.[11] Pregnant and postpartum non-Hispanic Black women were also more than two times more likely than non-Hispanic white women to die of hemorrhage or embolism.[12] The study also found that late maternal deaths—those occurring between six weeks and one year postpartum—were 3.5 times more likely among non-Hispanic Black women than non-Hispanic white women.[13] Postpartum cardiomyopathy was the leading cause of late maternal death among all races, with non-Hispanic Black women having a risk of death six times higher than non-Hispanic white women.[14]

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[6] *Id.*

[7] CDC, *Abortion Surveillance — United States, 2019*, 70 Surveillance Summaries 1, 8 (2021), available at <https://www.cdc.gov/mmwr/volumes/70/ss/pdfs/ss7009a1-H.pdf?>.

[8] Hoyert, *supra* note 5, at 1, 3–4.

[9] *Id.* at 3–4.

[10] MacDorman et al, *Racial and Ethnic Disparities in Maternal Mortality in the United States Using Enhanced Vital Records, 2016–17*, 111 Am J Pub Health 1673, 1673, 1676, 1678 tbl 2 (2021).

[11] *Id.* at 1678 tbl 2.

[12] *Id.*

[13] *Id.* at 1676.

[14] *Id.*

23. Every pregnancy necessarily involves significant physical change. A typical pregnancy generally lasts roughly 40 weeks LMP. During that time, the pregnant person experiences a dramatic increase in blood volume, as well as an increase in heart rate and in the amount of blood pumped with each heartbeat. Due to hormonal changes, the pregnant person's body produces more of the substances that cause blood to clot. The depth of each breath increases as well. The enlarging uterus and hormones produced by the placenta slow the patient's gastrointestinal tract and put pressure on the urinary tract.

24. As a result of these changes and others, pregnant individuals are more prone to blood clots, nausea and vomiting, dyspnea (breathing discomfort), hypertensive disorders, urinary tract infections, and anemia, among other complications.[15] Pregnant individuals are also at greater risk of certain infections.[16] Many of these complications are mild and resolve without the need for medical intervention. Some, however, require evaluation and occasionally urgent or emergent care to preserve the patient's health or save their life.

25. Pregnancy may aggravate preexisting health conditions such as hypertension and other cardiac disease, diabetes, kidney disease, autoimmune disorders, obesity, asthma, and other pulmonary disease. In 2020, approximately 14.6% of Michigan women had asthma;[17] an estimated 32.1% of Michigan women have hypertension, or 27.6% when adjusted for age, based on combined data from 2015 and 2017.[18]

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[15] Bruce et al, *Maternal Morbidity Rates in a Managed Care Population*, 111 Obstetrics & Gynecology 1089, 1092 (2008).

[16] See *id.* at 1091 tbl 1.

[17] Tian, *Prevalence Estimates for Risk Factors and Health Indicators, State of Michigan, Selected Tables, Michigan Behavioral Risk Factor Survey, 2020*, Mich Dep't of Health & Human Servs, Lifecourse Epidemiology & Genomics Div (2021), pp 8, 31 tbls 5, 28, available at <https://www.michigan.gov/documents/mdhhs/2020_BRFS_Tables_736718_7.pdf>.

[18] Mich Dep't of Health & Human Servs, *Estimated Hypertension Prevalence among Michigan Adults (2015 and 2017 Combined)*, p 1, available at https://www.michigan.gov/

26. Other health conditions may arise for the first time during pregnancy, such as preeclampsia, pregnancy-induced hypertension, deep-vein thrombosis, and gestational diabetes. Without adequate treatment, preeclampsia places the pregnant person at significant risk of cerebral hemorrhage (stroke), as well as liver dysfunction or failure, kidney failure, temporary or permanent vision loss, coma, and death. Patients with preeclampsia can also experience eclampsia, characterized by grand mal seizures. Many of these pregnancy-induced conditions are more common later in pregnancy. People who develop a pregnancy-induced medical condition are at higher risk of developing the same condition in a subsequent pregnancy.

27. Sometimes the nausea and vomiting commonly associated with "morning sickness" develops into a syndrome known as hyperemesis gravidarum. Hyperemesis gravidarum is characterized by vomiting so severe that it may result in dangerous weight loss; dehydration; acidosis from starvation; or hypokalemia, a potentially dangerous condition caused by a lack of potassium that can trigger psychosis, delirium, hallucinations, and abnormal heart rhythms, among other things. Pregnant people with this condition may require multiple hospital admissions throughout pregnancy.

28. Many pregnant people seek care in the emergency department at least once during pregnancy. People with comorbidities (including both people with preexisting comorbidities and those who develop comorbidities as a result of their pregnancy), such as asthma, obesity, hypertension, or diabetes, are significantly more likely to seek emergency care.

29. A relatively common complication of pregnancy is ectopic pregnancy, which occurs when a fertilized egg implants anywhere other than in the endometrial lining of the uterus, usually in a fallopian tube. If an ectopic pregnancy ruptures, it can kill the pregnant person;

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documents/mdhhs/HTN_Prevalence_MI_Adults_MI_BRFS_2015-2017_699103_7.pdf (accessed April 4, 2022).

ruptured ectopic pregnancy is a significant cause of pregnancy-related mortality and morbidity, and it is the leading cause of obstetric hemorrhage-related mortality. Ectopic pregnancies can also lead to scarring of the fallopian tube, leading in turn to fertility issues, and can compromise other organs.

30. Every pregnancy also carries a risk of miscarriage, as well as a risk of preterm premature rupture of membranes—in other words, the bag of waters surrounding the pregnancy breaking dangerously early. Complications from miscarriage can lead to infection, hemorrhage,[19] and even death. By comparison, the risk of death following a miscarriage is roughly twice the risk of death following an abortion (the risk of death following abortion is approximately 0.7 deaths per 100,000 procedures).[20]

31. Mental health conditions may emerge for the first time during pregnancy or in the postpartum period.[21] A person with a history of mental illness may also experience a recurrence of their illness, likely as a result of the hormonal and neurochemical changes their body is experiencing, and/or as a result of stress and anxiety relating to the pregnancy.[22] Additionally, a person taking medication to manage a mental health condition may choose to discontinue or modify their medication regimen to avoid risking harm to the fetus—thereby increasing the

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[19] Am College Obstetricians & Gynecologists (ACOG), Practice Bulletin No 200, *Early Pregnancy Loss* (Nov 2018), p e201, available at <https://static1.squarespace.com/static/5d3a2e1399c0960001b14452/t/5dc2031df1ffb26c011ff481/1572995870418/ACOG+EPL+Bulletin_update.pdf>.

[20] Nat'l Academies of Sciences, Engineering, & Med, *The Safety & Quality of Abortion Care in the United States* (2018), p 75 tbl 2-4.

[21] Yonkers et al, *Diagnosis, Pathophysiology, and Management of Mood Disorders in Pregnant and Postpartum Women*, 117 Obstetrics & Gynecology 961, 963 (2011); see also Bruce et al, *supra* note 15, at 1093.

[22] Yonkers, *supra* note 21, at 964–67.

likelihood that they will experience a recurrence of their mental illness.[23] Pregnant people with a prior history of mental health conditions also face a heightened risk of postpartum mental illness.[24]

32. Separate from pregnancy, childbirth itself is a significant medical event.[25] Even a normal pregnancy can suddenly become life-threatening during labor and delivery, when 20% of the pregnant person's blood flow is diverted to the uterus. This increased blood flow places the patient at risk of hemorrhage and, in turn, death; indeed, hemorrhage is the leading cause of severe maternal morbidity.[26] As mentioned above, during pregnancy—to try to protect against hemorrhage—the body produces more clotting factors, which increases the pregnant person's risk of developing blood clots or embolisms. This heightened risk of blood clots extends past delivery into the postpartum period.

33. People who undergo labor and delivery can experience other unexpected adverse events such as transfusion, perineal laceration, ruptured uterus, and unexpected hysterectomy.

34. In 2017, approximately 31.9% of Michigan deliveries were by cesarean section (C-section),[27] an open abdominal surgery requiring hospitalization for at least a few days. While common, C-sections carry risks of hemorrhage, infection, and injury to internal organs.

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[23] See, e.g., Diav-Citrin et al, *Pregnancy Outcome Following In Utero Exposure to Lithium: A Prospective, Comparative, Observational Study*, 171 Am J of Psychiatry 785, 789–90 (2014) (finding increased risk of cardiovascular anomalies among lithium-exposed pregnancies).

[24] Marcus, *Depression During Pregnancy: Rates, Risks and Consequences*, 16 J Population Therapeutics & Clinical Pharmacology e15, e18–e19 (2009).

[25] See, e.g., Mich Dep't of Health & Human Servs, Div for Vital Records & Health Statistics, *Number of Live Births by Maternal Morbidity and Onset of Labor by Race and Ancestry of Mother, Michigan Residents, 2020* <https://www.mdch.state.mi.us/osr/natality/MorbidityRaceNo.asp> (accessed April 4, 2022); Mich Dep't of Health & Human Servs, *Overview of Severe Maternal Morbidity in Michigan 2011–2019* (2021), available at <https://www.michigan.gov/documents/mdhhs/SMM_Report_Final_10.5.21_737494_7.pdf>.

[26] ACOG, Practice Bulletin No 183, *Postpartum Hemorrhage*, 130 Obstetrics & Gynecology e168, e168 (2017).

[27] CDC, Nat'l Ctr for Health Statistics, *Stats of the State of Michigan* (April 11, 2018) <https://www.cdc.gov/nchs/pressroom/states/michigan/michigan.htm> (accessed April 4, 2022).

Meanwhile, a vaginal delivery often leads to injury, such as injury to the pelvic floor. This can have long-term consequences, including fecal or urinary incontinence.

35. Pregnancy and childbirth are expensive. Pregnancy-related health care and childbirth are some of the costliest hospital-based health services.[28] On average, vaginal birth costs over $15,300, and a C-section costs over $20,400—and costs can be much higher for complicated or at-risk pregnancies.[29] I am aware of physicians in private practice who routinely help their obstetric patients create payment plans to afford the cost of labor and delivery.

36. While insurance may cover most of these expenses, many pregnant patients with insurance must still pay for significant labor and delivery costs out of pocket. A recent study found that 98% of women on employer-sponsored insurance had to pay out-of-pocket costs from childbirth.[30] Out-of-pocket costs today average around $4,314 for vaginal deliveries and $5,161 for C-sections.[31]

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[28] Allsbrook & Ahmed, *Building on the ACA: Administrative Actions to Improve Maternal Health*, (March 25, 2021), Ctr for Am Progress <https://www.americanprogress.org/article/building-aca-administrative-actions-improve-maternal-health>/ (accessed April 4, 2022), citing Wier & Andrews, Healthcare Cost & Utilization Project, Statistical Brief #107, *The National Hospital Bill: The Most Expensive Conditions by Payer, 2008* (2011), available at <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb107.jsp>.

[29] *Id.*, citing Sonfield, *No One Benefits If Women Lose Coverage for Maternity Care*, Guttmacher Institute (2017), available at <https://www.guttmacher.org/gpr/2017/06/no-one-benefits-if-women-lose-coverage-maternity-care>. Some sources show even higher rates for both vaginal delivery and C-section. See, e.g., Truven Health Analytics, *The Cost of Having a Baby in the United States* (2013), p 6, available at <https://www.nationalpartnership.org/our-work/resources/health-care/maternity/archive/the-cost-of-having-a-baby-in-the-us.pdf> (finding the "average total charges for care with vaginal and cesarean births" among "women and newborns with employer-provided Commercial health insurance" to be "$32,093 and $51,125, respectively").

[30] Moniz et al, *Out-of-Pocket Spending for Maternity Care Among Women with Employer-Based Insurance, 2008-15*, 39 Health Affairs 18, 20 (2020).

[31] *Id.*

37. Of course, the financial burdens of pregnancy and childbirth weigh even more heavily on people without insurance, who are disproportionately people of color,[32] and on people with unintended pregnancies, who may not have sufficient savings to cover pregnancy-related expenses.[33] Almost half of the pregnancies in the U.S. are unintended, and people of color and people with low incomes experience unintended pregnancy at a disproportionately higher rate,[34] in large part due to systemic barriers to contraceptive access.[35] According to the Federal Reserve, nearly 40% of Americans cannot cover an unexpected $400 expense.[36] Roughly 14% of people of reproductive age do not have health insurance,[37] and even more are under-insured, meaning they lack full coverage for needed services[38] and may need to pay out-of-pocket. A costly pregnancy, particularly for people already facing an array of economic hardships, could have long-term and severe impacts on a family's financial security.[39]

38. Pregnant people may also face an increased risk of intimate partner violence. According to the American College of Obstetricians and Gynecologists (ACOG), "the severity of

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[32] Allsbrook & Ahmed, *supra* note 28.

[33] *Id.*

[34] Guttmacher Institute, *Unintended Pregnancy in the United States* (2019), p 1, available at <https://www.guttmacher.org/sites/default/files/factsheet/fb-unintended-pregnancy-us.pdf>.

[35] ACOG, Committee Opinion No 615, *Access to Contraception* (2015), p 5, available at <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2015/01/access-to-contraception.pdf>; Sudhinaraset et al, *Women's Reproductive Rights Policies and Adverse Birth Outcomes: A State-Level Analysis to Assess the Role of Race and Nativity Status*, 59 Am J Preventive Med 787, 788 (2020).

[36] Bd of Governors of the Fed Reserve Sys, *Report on the Economic Well-Being of U.S. Households in 2018 - May 2019* (May 28, 2019), available at <https://www.federalreserve.gov/publications/2019-economic-well-being-of-us-households-in-2018-dealing-with-unexpected-expenses.htm>.

[37] Adam Sonfield, *Uninsured Rate for People of Reproductive Age Ticked up Between 2016 and 2019*, Guttmacher Institute (April 1, 2021), available at <https://www.guttmacher.org/print/article/2021/04/uninsured-rate-people-reproductive-age-ticked-between-2016-and-2019>.

[38] Allsbrook & Ahmed, *supra* note 28.

[39] See *id.*

intimate partner violence may sometimes escalate during pregnancy or the postpartum period,"[40] and "[h]omicide has been reported as a leading cause of maternal mortality, with the majority perpetrated by a current or former intimate partner."[41] According to the U.S. Centers for Disease Control and Prevention (CDC), 36.1% of Michigan women experience contact sexual violence,[42] physical violence, and/or stalking victimization by an intimate partner in their lifetime.[43] An estimated 51.9% of Michigan women—approximately 2,028,000 women—experience psychological aggression from an intimate partner in their lifetime.[44] Women who have experienced intimate partner violence and who give birth after being unable to access a desired abortion will, in many cases, face increased difficulty escaping that relationship.[45]

39. A person carrying a pregnancy to term may also experience post-pregnancy mental health issues. According to a reported systematic review of the literature, the global prevalence of postpartum depression among healthy women without a history of depression and who give birth to healthy full-term infants is about 17%.[46] In 2018, 13.4% of Michigan women reported experiencing symptoms of depression since giving birth.[47] Similarly, a reported systematic review

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[40] ACOG, Committee Opinion No 518, *Intimate Partner Violence* (2012, reaff'd 2019), p 2, available at <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2012/02/intimate-partner-violence.pdf>.

[41] *Id.*

[42] The CDC defines this term as "a combined measure that includes rape, being made to penetrate someone else, sexual coercion, and/or unwanted sexual contact." Smith et al, CDC, Nat'l Ctr for Injury Prevention & Control, *The National Intimate Partner and Sexual Violence Survey, 2010–2012 State Report* (2017), p 19, available at <https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf.>

[43] *Id.* at 128 tbl 5.7.

[44] *Id.* at 134 tbl 5.9.

[45] See Roberts et al, *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 BMC Med 144, 149 (2014).

[46] Shorey et al, *Prevalence and Incidence of Postpartum Depression Among Healthy Mothers: A Systematic Review and Meta-Analysis*, 104 J Psychiatric Research 235, 238 (2013).

[47] Mich Dep't Health & Human Servs, *Pregnancy-Related Depression* (July 2018), p 1, available at <https://www.michigan.gov/documents/mdhhs/Pregnancy_Related_Depression_APPROVED_alt_text_7.18.2018_628203_7.pdf>.

of the literature examining the prevalence of anxiety disorders among postpartum women estimated that approximately 8.5% of postpartum women experience one or more anxiety disorders.[48]

40. Beyond childbirth, raising a child is expensive, both in terms of direct costs and due to lost wages. On average, women experience a large and persistent decline in earnings following the birth of a child, an economic loss that compounds the additional costs associated with raising a child, which typically exceed $9,000 in annual expenses.[49] In Michigan, the cost of child care for a parent with two children in a Michigan child care center is approximately $18,600 a year—exceeding the average annual cost of rent ($9,900) or a mortgage ($15,000).[50]

41. Given the impact of pregnancy and childbirth on a person's mental and physical health, finances, and personal relationships, whether to become or remain pregnant is one of the most personal and consequential decisions a person will make in their lifetime. Certainly, many people decide that adding a child to their family is well worth all of these risks and consequences. But no one should be forced to assume those risks involuntarily. As discussed below, I am gravely concerned that if abortion becomes unavailable in Michigan—as might happen any day now—thousands of pregnant people in this state will be forced to do so.

Background on Abortion

42. Abortion is one of the safest and most common medical services performed in the United States today. Indeed, abortion carries far fewer risks than childbirth. A woman's risk of

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[48] Goodman, Watson, & Stubbs, *Anxiety Disorders in Postpartum Women: A Systematic Review and Meta-Analysis,* 203 J of Affective Disorders 292, 328 & tbl 8 (2016).

[49] Miller, Wherry, & Foster, *The Economic Consequences of Being Denied an Abortion*, NBER Working Paper No 26662 (revised January 2022), p 2, available at <https://www.nber.org/system/files/working_papers/w26662/w26662.pdf>.

[50] Mich League for Pub Policy, *2021 Budget Priority: Help Parents with Low Wages Find Affordable Child Care* (2019), p 1, available at <https://mlpp.org/wp-content/uploads/2019/07/2021-budget-priority-child-care-pat.pdf>.

death associated with childbirth, specifically, is more than 12 times higher than that associated with abortion,[51] and the total risk of maternal mortality is 34 times higher than the risk of death associated with abortion.[52] Every pregnancy-related complication is more common among women having live births than among those having abortions.[53] Of the 29,669 induced abortions in Michigan in 2020, the Michigan Department of Health reported just seven immediate complications.[54] The average three-year rate of immediate abortion complications between 2017 and 2019 was 3.5 per 10,000 induced abortions: just 0.035%.[55] Approximately one in four women in this country will have an abortion by age forty-five.[56]

43. There are two general categories of methods used to provide abortion: medication abortion and procedural abortion.[57]

44. For early medication abortion, patients take a regimen of two prescription drugs approved by the U.S. Food and Drug Administration (FDA): mifepristone, which blocks progesterone, a hormone necessary to continue a pregnancy; and misoprostol, which softens the cervix and causes the uterus to contract and empty. Patients first take the mifepristone, then 0 to

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[51] Nat'l Academies of Sciences, Engineering, & Med, *supra* note 20, at 75 tbl. 2-4 (finding a mortality rate of 0.7 per 100,000 procedures for abortion and a mortality rate of 8.8 per 100,000 live births for childbirth).

[52] Hoyert, *supra* note 5, at 1 (finding an overall maternal mortality rate of 23.8 per 100,000 live births).

[53] Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216–17 & fig 1 (2012).

[54] Mich Dep't of Health, Div for Vital Records & Health Stats, *Table 22, Number, Percent and Rate of Reported Induced Abortions with Any Mention of Immediate Complication by Type of Immediate Complication, Michigan Occurrences, 2020* <https://www.mdch.state.mi.us/osr/abortion/Tab_13.asp> (accessed April 4, 2022).

[55] *Id.*

[56] Jones & Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 Am J Pub Health 1904, 1904, 1908 (2017).

[57] The only other medically-proven method of abortion is induction. Induction abortion uses medications to induce labor in a hospital, but accounts for only a small percentage of abortions in the United States.

48 hours later, they take the misoprostol at a location of their choosing, typically at home. Together, the medications cause the pregnancy to pass in a process similar to miscarriage.

45. The use of mifepristone in combination with misoprostol is evidence-based and widely used to terminate pregnancies through 11 weeks (or 77 days) LMP. Accordingly, through 11 weeks LMP, patients wishing to terminate their pregnancies may choose between medication and procedural abortion. After 11 weeks LMP, only procedural abortion is generally available.

46. For procedural abortion, a clinician uses instruments and/or medication to widen the patient's cervical opening and to evacuate the contents of the uterus. Procedural abortion is a straightforward and brief procedure. It is almost always performed in an outpatient setting and sometimes involves local anesthesia or conscious sedation to make the patient more comfortable. Although procedural abortion is sometimes referred to as "surgical abortion," it is not what is commonly understood to be surgery, as it involves no incisions, no need for general anesthesia, and no need for a sterile field.

47. Up to approximately 14 weeks LMP, procedural abortion relies on the aspiration technique, where the clinician inserts a thin, flexible tube through the patient's cervical opening and uses gentle suction to empty the uterus. After approximately 14 weeks LMP, procedural abortion involves the dilation and evacuation (D&E) technique, where the clinician uses instruments as well as aspiration to empty the uterus. Starting around 18 to 20 weeks LMP, an additional procedure may be performed to ensure that the patient's cervix is adequately dilated for the procedural abortion. This may occur on the same day as the abortion, or the day prior to the abortion.

48. As mentioned above, Michigan law creates additional, medically unnecessary steps that we must follow when providing either a medication abortion or a procedural abortion: patients must receive certain state-mandated information at least 24 hours before the abortion, and patients

who are minors must either obtain written parental consent or obtain permission from a judge through a legal proceeding that can take several days to complete.

49. There is no typical abortion patient, and pregnant people seek abortions for a variety of deeply personal reasons. In addition to cisgender women, gender-nonconforming people, transmasculine people, and trans men have abortions.[58] Some people have abortions because they conclude that it is not the right time in their lives to have a child or to add to their families.[59] Some decide to end a pregnancy because they want to pursue their education[60] or because of the negative impact pregnancy would have on their current employment or employment opportunities. Some people have an abortion because they feel they lack the necessary economic resources or an adequate level of family or partner support or stability to parent a child.[61] Some decide to have an abortion because they do not want children at all.[62] Some people decide to end their pregnancy because it is dangerous to their mental or physical health, including by worsening a pre-existing condition or triggering the onset of a new condition.

50. Nearly 60% of abortion patients nationally already have at least one child.[63] Most also report plans to have children (or additional children)[64] at another time in their lives.

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[58] To reflect this reality, in this affidavit I generally use the phrase "pregnant person" rather than "pregnant woman." I occasionally use "woman" or "women" as a short-hand for people who are or may become pregnant, while recognizing that people of all gender identities may become pregnant and seek abortion services. I also use "woman" or "women" when citing or quoting research that reports its results in terms of "women," to preserve the accuracy of those results.

[59] Biggs, Gould, & Foster, *Understanding Why Women Seek Abortions in the US*, 13 BMC Women's Health e1, e5–e8 (2013); Finer et al, *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 Perspectives on Sexual & Reproductive Health 110, 112 (2005).

[60] Biggs, Gould, & Foster, *supra* note 59, at e7; Finer et al, *supra* note 59, at 112.

[61] Biggs, Gould, & Foster, *supra* note 59, at e5–e7; Finer et al, *supra* note 59, at 112.

[62] Biggs, Gould, & Foster, *supra* note 59, at e8.

[63] Jerman, Jones, & Onda, *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Institute (May 2016), p 7, available at <https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf>.

[64] Henshaw & Kost, *Abortion Patients in 1994–1995: Characteristics and Contraceptive Use*, 28 Family Planning Perspectives 140, 144 (1996), available at <https://www.guttmacher.org/sites/

51. At PPMI, between July 2020 and June 2021, 27% of abortion patients had incomes below 101% of the federal poverty level, and an additional 22% had incomes between 100% and 200% of the federal poverty level.[65] In 2020, 200% of the federal poverty level was $25,520 annually for a household of one, and $34,480 annually for a household composed of one parent and one child.[66] The vast majority—93%—of PPMI abortion patients between July 2020 and June 2021 paid for their abortions out of pocket rather than with insurance.

52. Nearly three-fourths of abortion patients say they cannot afford to become a parent or to add to their families, and the same proportion also cites responsibility to other individuals (such as children or elderly parents), or that having a baby would interfere with work and/or school, as their reason for ending their pregnancy.[67]

53. Some people seek abortions because they are experiencing intimate partner violence. Many of these patients fear that carrying the pregnancy to term and giving birth would further tie them to their abusers. In some circumstances, people experiencing intimate partner violence may face additional risk of violence if their partner learns of their pregnancy or desire for an abortion.

54. Some people seek abortions because the pregnancy is the result of rape.

55. Some people decide to have an abortion because of an indication or diagnosis of a fetal medical condition. Some families feel they do not have the resources—financial, medical,

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default/files/pdfs/pubs/journals/2814096.pdf>.

[65] Because 33% of PPMI abortion patients in that time frame did not report their income level, the actual percentages could be even higher.

[66] See US Dep't of Health & Human Servs, Ass't Secretary for Planning & Evaluation, *2020 Poverty Guidelines* <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references/2020-poverty-guidelines> (2020) (listing the federal poverty level for a household of one as $12,760 and for a household of two as $17,240) (accessed April 4, 2022).

[67] Finer et al, *supra* note 59, at 112.

educational, or emotional—to care for a child with special needs, or to do so while providing for the children they already have.

56. Some people decide to have an abortion because of a fetal medical diagnosis that means after delivery the baby would never be healthy enough to go home. While some may decide to carry such a pregnancy through delivery, others may decide that they wish to terminate the pregnancy.

57. Some abortion patients with high-risk pregnancies—because of advanced maternal age or some other underlying medical condition—have complications that lead them to end their pregnancies to preserve their own life or health. Such underlying medical conditions include severe cardiovascular disease, sickle-cell disease, congenital heart disease, severe liver or kidney disease, and autoimmune disease. Complications requiring abortion to save the pregnant person's life or health include eclampsia, ectopic pregnancy, and infection resulting from a preterm premature rupture of membranes.

58. In summary, the decision to terminate a pregnancy is often motivated by a combination of complex and interrelated factors that are intimately tied to the pregnant person's identity, values, culture, religion, mental and physical health, family circumstances, and resources and economic stability. The decision is often made with the support of the person's partners, loved ones, family, friends, and other support networks, including support networks that are religious and spiritual.

My Medical Practice as an Abortion Provider

59. Since the first year of my medical residency in the OB/GYN department at the University of Michigan Medical School, I have provided both medication abortion and procedural

abortion. In fact, I first began my abortion training during my rotation at a Planned Parenthood health center here in Michigan, in 2009.

60. At PPMI, I currently provide medication abortion through 11 weeks LMP and procedural abortion through 19 weeks, 6 days LMP.

61. I came to this work rather deliberately. I attended college knowing that I wanted to become a doctor, and I went to medical school knowing that I wanted to help women. I became an OB/GYN knowing that providing abortions was an integral part of the care that women require and deserve.

62. Still, I had not considered becoming an abortion provider myself until I was actually in medical school. I was raised in a Christian home in Lexington, South Carolina. My family went to church regularly and said prayers before meals, and I grew up understanding that it was my duty to leave the world a better place than I found it. Abortion was something we never talked about at home; I had neither negative nor positive feelings about it. But to fulfill my moral responsibility to help people in need, I knew I wanted to take care of women and people who can become pregnant, so I decided to become an OB/GYN, and I came to Michigan for that training.

63. In medical school, I noticed that some of the people who I worked with and respected took care of abortion patients in a way that stigmatized those patients, and it negatively impacted the care that those patients received. The patients themselves often seemed to feel as though they needed to justify their desire to have an abortion in order to receive the care they deserved. I came to understand that providing abortion with respect and compassion was something I could do to make a significant difference in people's lives, particularly when others would not.

64. Once I had the opportunity to start working for Planned Parenthood, it just felt right. It matched my core values, shaped by my faith and upbringing. I could care for people without judgment, and with respect and compassion. Unlike when I was working in other settings, at Planned Parenthood I did not have to justify to anyone why providing abortion is important.

65. Today, abortion constitutes the majority of the clinical care I provide—not because I could not provide other care, but because the need for abortion providers is so great.

66. The patients I see every day are so clearly people in need, and the compassion and empathy I learned from my faith are fundamental to my work. I am proud to provide abortion to people in Michigan, and to train other medical students, residents, and fellows to provide compassionate, respectful, high-quality abortion services.

67. Providing abortion in Michigan is both similar to and different from providing abortion in other parts of the country. At PPMI, I see abortion patients who travel to Michigan from other states, most commonly Ohio and Indiana, but also from Wisconsin. We do not affirmatively ask out-of-state patients why they have come to Michigan to obtain an abortion, but sometimes people volunteer that one of our PPMI health centers was the closest access point for them. Others explain that in their home state, they would have been required to make two separate trips to the health center, and that traveling a farther distance one time was less difficult than making two separate trips in their home state. Recently, I even saw a patient from Texas, who came all the way to Michigan after Texas effectively outlawed abortion after approximately six weeks' gestation through its S.B. 8 law.

68. Michigan has significant barriers to abortion access, most notably travel obstacles: in many parts of the state, people have to drive hours to reach a health center that provides abortion. In the Upper Peninsula, there is only one PPMI health center, and it only provides medication

abortion—meaning patients who are past 11 weeks LMP cannot access abortion there at all. Additionally, in Michigan we do not have a robust public-transportation network. Even in metro Detroit, where there are a number of abortion providers, you could be just as out of luck as in rural parts of the state, because without a personal vehicle or a comprehensive bus system, there is no way for someone to get where they need to be.

69. People who are able to access abortion in Michigan frequently still contend with abortion stigma. For example, in parts of the state without a supportive medical community, I worry all the time that other medical providers will not be kind to our patients in the event that they need follow-up care. Worse, I worry that some of our patients will be scared away from seeking needed medical care at all. We already see this with some of our rural patients—in the rare event that someone needs follow-up care after an abortion, they would rather drive a long distance to see us at PPMI than obtain that care closer to home, simply because they do not want anyone closer to home to know that they have terminated a pregnancy.

70. Of course, what abortion ultimately means for patients is the same no matter where they live. Abortion allows people to have control over their bodies and their futures. It makes it possible for them to care for the families they already have, or to escape a dangerous situation in their own home. It alleviates serious medical risks caused or worsened by pregnancy. It brings peace to people who experience pregnancy as a violation of their truest selves. Put simply, abortion is a life-changing and often life-saving procedure that can be and often is positive, not just for patients but also for their loved ones and their communities.

The Consequences of Banning Abortion in Michigan

71. Though I and other PPMI physicians provide abortion that is outlawed by the text of the Criminal Abortion Ban presently on the books, I understand that a Michigan Supreme Court

decision currently protects me and other abortion providers from being criminally prosecuted under that statute. Still, that protection could disappear any day now, since the United States Supreme Court's decision in the *Dobbs v Jackson Women's Health Organization* case could modify *Roe v Wade*—the case on which the Michigan Supreme Court decision relies.

72. I am not a lawyer, but I know that people seeking abortion in Michigan will be confused and panicked if the law changes and if the Criminal Abortion Ban becomes enforceable, outlawing abortion in the state. My patients will not know whether they can still come to PPMI for care, or whether they need to try to make arrangements to travel out of state. This uncertainty will disrupt our ability to care for our patients even before any government official takes a step to enforce the Ban.

73. In addition to the risk of criminal prosecution, I understand that the Michigan Department of Licensing and Regulatory Affairs could revoke my medical license for providing an abortion in violation of the Criminal Abortion Ban as written.[68] And the insurance company that provides my medical malpractice insurance might cancel my coverage even before the licensing action was finalized.[69] Without my medical license or malpractice insurance, I would no longer be able to provide *any* medical care in Michigan.

74. Furthermore, certain parts of the Criminal Abortion Ban as written are unclear to me, as the statute uses certain terms in a way that is inconsistent with medical terminology. For example, I understand that the law makes it a felony to "procure [a] miscarriage." In medical practice, "miscarriage" is used interchangeably with the terms "spontaneous abortion" and "early

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[68] Kaffer, *Opinion: Prosecution Wouldn't Be Only Option for Abortion Foes in a Post*-Roe *Michigan*, Detroit Free Press (March 26, 2022) <https://www.freep.com/story/opinion/columnists/nancy-kaffer/2022/03/26/roe-abortion-supreme-court-michigan/7146616001/> (accessed April 4, 2022).

[69] *Id.*

pregnancy loss," and generally refers to "a nonviable, intrauterine pregnancy with either an empty gestational sac or a gestational sac containing an embryo or fetus without fetal heart activity."[70] Because "miscarriage" is something that happens spontaneously, medical professionals would not describe abortion as "procuring a miscarriage."[71] Moreover, I am aware that in Michigan and elsewhere, people who lack a complete or accurate understanding of reproductive medicine may interpret the Criminal Abortion Ban to criminalize conduct that is not abortion at all, such as prescribing emergency contraception.[72]

75. If the Criminal Abortion Ban were enforced as written in Michigan, my colleagues at PPMI and I would be forced to stop providing abortion under virtually any circumstance—that, or face felony prosecution and licensure penalties. In turn, PPMI would no longer be able to offer abortion at its health centers. The Ban would thus have devastating consequences for my patients, for PPMI, and for me personally.

76. If abortion were unavailable in Michigan, many people would not be able to travel to another state to access abortion, or would be significantly delayed by the cost and logistical arrangements required to do so. Already, people living in poverty forgo or delay other basic needs, like rent or groceries, to pay for their abortions and all the associated logistical expenses, such as travel costs, childcare, and time away from work. Many people need to borrow money from family

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[70] ACOG, Practice Bulletin No 200, *supra* note 19, at e197.

[71] See generally *id.*

[72] E.g., Reilly, *Missouri Lawmakers Pretended IUDs Cause Abortion. They Lost*, ReWire News Grp (June 28, 2021) <https://rewirenewsgroup.com/article/2021/06/28/missouri-lawmakers-pretended-iuds-cause-abortion-they-lost/> (accessed April 4, 2022) (Missouri legislators incorrectly characterizing emergency contraception and IUDs as abortion); Filipovic, *How Ohio Became One of the Worst States for Reproductive Rights in the Country*, Cosmopolitan (June 6, 2014) <https://www.cosmopolitan.com/politics/news/a7129/ohio-abortion-laws/> (accessed April 4, 2022) (same in Ohio); Verlee, *Colorado Debates Whether IUDs Are Contraception or Abortion*, Nat'l Pub Radio (March 5, 2015) <https://www.npr.org/sections/health-shots/2015/03/05/391030821/colorado-debates-whether-iuds-are-contraception-or-abortion> (accessed April 4, 2022) (same in Colorado).

and friends to pay for care, which takes time. Navigating inflexible or unpredictable work schedules and child care needs further delays or prevents our patients accessing care.

77. On top of these existing obstacles, many people traveling long distances to an abortion appointment out of state would need to raise additional money to afford the travel. Many would also need to arrange for childcare and time off work while they are away. The need to travel could thus significantly delay people in accessing care. And because abortion becomes more expensive as pregnancy progresses, people trying to save money for an abortion, plus money to pay for the necessary travel out of state, could find themselves in a vicious cycle: as the process of raising the necessary funds delays them in obtaining care, the amount of money required grows, resulting in more delay. This delay could, in turn, push some people past the point in pregnancy where abortion is legally or practically available in nearby states, forcing them to carry the pregnancy to term against their will.

78. I am mindful that, currently, people travel to Michigan for an abortion because for some it is easier to access abortion here than in surrounding states. If abortion were illegal in Michigan, I worry that both people from Michigan and people from those other states would be unable to access abortion at all.

79. Delays in accessing abortion, or being unable to access abortion at all, pose risks to patients' health. While abortion is very safe at any point in pregnancy, the risks of abortion increase with gestational age.[73] And because pregnancy and childbirth are far more medically risky than abortion, forcing people to carry a pregnancy to term exposes them to an increased risk of physical harm. If abortion is no longer available, people will instead be forced to remain pregnant and give

[73] Nat'l Academies of Sciences, Engineering, & Med, *supra* note 20, at 77–78, 163 & tbl 5-1.

birth in a health care system that does not adequately keep pregnant people safe, especially pregnant people of color.

80. Further, a person's ability to access abortion has consequences not only for that person, but also for their family and community. Longitudinal research assessing the short- and long-term consequences of being denied an abortion demonstrates the negative impacts not only on the person's mental health,[74] on their professional prospects,[75] and on their finances,[76] but also on the well-being of their existing children[77] and of the child the person is forced to have.[78]

81. The COVID-19 pandemic has exacerbated these consequences, as access to affordable child care has been strained and women have been forced out of the workforce to care for children at rates vastly disproportionate to men. Since the start of the pandemic, women have lost a net five million jobs, and 2.3 million women have left the workforce entirely, likely as a result of child care obligations.[79]

82. Enforcing the Criminal Abortion Ban would most harm pregnant people who are poor or have low incomes, pregnant people living in rural counties or urban areas without access

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[74] Biggs et al, *Women's Mental Health and Well-being 5 Years After Receiving or Being Denied an Abortion*, J Am Med Ass'n Psychiatry E1, E3–E6 (2017).

[75] Upadhyay, Biggs, & Foster, *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15 BMC Women's Health e1, e4, e6 (2015).

[76] Miller, Wherry, & Foster, *supra* note 49, at 36.

[77] Foster et al, *Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children*, 205 J of Pediatrics 183, 185, 187 (2019); see also Foster et al, *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 Am J Pub Health 407, 411–12 (2018) (finding that denial of a wanted abortion exacerbates socioeconomic hardships).

[78] Foster et al, *Comparison of Health, Development, Maternal Bonding, and Poverty Among Children Born After Denial of Abortion vs After Pregnancies Subsequent to An Abortion*, 172 J Am Med Ass'n 1053, 1056–59 (2018); see also Foster et al, *Socioeconomic Outcomes of Women*, *supra* note 77, at 411–12.

[79] Nat'l Women's Law Ctr, *A Lifetime's Worth of Benefits: The Effects of Affordable, High-Quality Child Care on Family Income, the Gender Earnings Gap, and Women's Retirement Security* (2021), p 1, available at <https://nwlc.org/wp-content/uploads/2021/04/Lifetime-Fact-Sheet.pdf>.

to adequate prenatal care or obstetrical providers, and Black pregnant people in Michigan. Nationwide, three out of four abortion patients are poor or live on low incomes (up to 200% of the federal poverty level).[80] A majority of people in Michigan who had an abortion in 2020 identified as Black;[81] in Michigan and nationally, Black patients seek abortions at a higher rate than white patients due to disparities caused by a long history of structural racism—specifically, unequal access to quality family-planning services, economic disadvantage,[82] and other social determinants of health such as limited access to "safe and affordable housing, quality education, healthy food, [and] stable employment."[83] As discussed above, pregnancy is more dangerous for Black women than it is for white women: as of 2020, the national maternal mortality rate for Black women is approximately three times the rate for white women,[84] a consequence of structural and systemic racism. Banning abortion in Michigan would force Black women to bear this disproportionate risk to their health and their lives.

83. Because the Criminal Abortion Ban does not allow exceptions for pregnancies resulting from rape or incest, it would have a uniquely devastating impact on survivors of those crimes, who would be forced either to carry the pregnancy to term or to find a way to access abortion in another state.

84. If abortion were outlawed in Michigan, given the barriers to accessing abortion out of state, I expect that some people would find ways to self-manage abortion. Some who do may

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[80] Jerman, Jones, & Onda, *supra* note 63, at 11.

[81] Mich Dep't of Community Health, *Table 11, Number and Percent of Reported Induced Abortions by Race or Hispanic Ancestry of Woman, Michigan Residents, 2020* <https://www.mdch.state.mi.us/osr/abortion/Abortrace.asp> (accessed April 4, 2022).

[82] CDC, *Abortion Surveillance — United States*, *supra* note 7, at 7.

[83] Mich Dep't of Health & Human Servs, *2020 Health Equity Report, Moving Health Equity Forward*, p 4 (2021), available at <https://www.michigan.gov/documents/mdhhs/2020_PA653-Health_Equity_Report_Full_731810_7.pdf>.

[84] Hoyert, *supra* note 8, at 1, 3–4.

experience one of the rare complications from medication abortion. As I described earlier, people in Michigan are already afraid to tell their doctors that they have had a *legal* abortion, and I am deeply concerned that, if the Criminal Abortion Ban is enforced, people who experience complications after self-managing their abortions will be too afraid to seek necessary follow-up care. Those people could be seriously harmed—not because abortion is unsafe, but because the Criminal Abortion Ban has made it unsafe for them to be fully open with their medical providers and prevented them from accessing accurate medical information.

85. Given the Criminal Abortion Ban's extraordinarily narrow exception for abortions necessary to preserve the pregnant person's life, I fear that pregnant people with dangerous medical conditions will be forced to wait to receive an abortion—even an urgently medically necessary abortion—until they are literally dying. I understand that this is already happening in Texas, where emergency-room physicians are afraid to terminate patients' pregnancies even where doing so would avert serious medical risk to the patient because they are afraid of being sued for violating Texas's law banning abortion at roughly six weeks.[85]

86. I recently had a glimpse of what this world might look like when I saw a patient whose pregnancy was past the legal gestational age limit for abortion in Michigan. When I told this patient that I was not able to provide her an abortion, she sobbed in a way I had not heard in a very long time. She did not want to be pregnant, she was not prepared to decide between parenting and adoption, and traveling out of state was not an option. She left my office with resources, but I felt helpless.

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[85] Nat'l Pub Radio, *Doctors' Worst Fears About the Texas Abortion Law Are Coming True* (March 1, 2022) <https://www.npr.org/2022/02/28/1083536401/texas-abortion-law-6-months> (accessed April 4, 2022).

87. If I could not provide abortion in Michigan, that is how I would feel with every single patient. Over and over again, I would have to deliver news that would change someone's entire life against their wishes. Despite knowing that I have the resources and the medical training to help them safely, I would have to tell each person *I'm sorry, I can't help you, because it is a crime for me to provide you with the medical care that you need.*

88. Absent enforcement of the Criminal Abortion Ban, PPMI will continue to provide both medication and procedural abortion in Michigan. But if the Criminal Abortion Ban were enforced against physicians who provide abortion in Michigan, PPMI would be forced to stop offering abortion to our patients.

89. The Criminal Abortion Ban would directly harm PPMI's mission to provide comprehensive sexual and reproductive health care to the communities we serve, and PPMI's standing in the eyes of our patients and supporters. Our patients know PPMI as a trusted, nonjudgmental provider. People trust us with their most personal information and questions, and that allows us to provide the highest-quality sexual and reproductive health care. But if we could no longer provide abortion when people come to us and ask for that care, some patients might misunderstand why we are no longer providing abortion and think that it is because we no longer want to. That would badly undermine our patients' trust in us. People might be afraid to tell us that they have self-managed abortion or that they are planning to travel out of state to obtain abortion elsewhere. We would no longer be seen as a safe place where people can be open and honest about their health care histories and needs. This would not only harm our reputation as a health care provider; it would interfere with our ability to provide other care.

90. Additionally, I worry that some PPMI staff would be afraid to continue working at PPMI if the Criminal Abortion Ban were being enforced against abortion providers. Even if we all

complied with the law, a prosecutor somewhere might accuse us of violating it, or open an invasive investigation into PPMI's practices. Some staff might prefer to leave PPMI rather than continue working with those threats hanging over them. Other staff might simply be unable to bear turning patients away in their time of need, over and over again.

91. Finally, enforcing the Criminal Abortion Ban would harm me personally. My work as an abortion provider is a core part of my identity. It is also my area of professional expertise. If I were no longer able to provide abortion in Michigan, I would face the hard choice between staying here and continuing to provide other medical care to Michigan patients, or uprooting my life and my family and moving to a state where abortion remains legal so that I could use my extensive training to continue to provide this vitally important health care. If I stayed in Michigan, I would be forced to stop providing the specific category of medical care that I am trained in and highly skilled at, and I would not be allowed to provide the care that my patients need. It would feel unethical and immoral to deny my patients medical care that they need and that I am highly trained to provide safely. I would find it challenging to provide any other OB/GYN care in such an environment. Other abortion providers in Michigan would face this same choice, and I know that some are already weighing their options. I am also concerned that medical students and residents in Michigan would no longer be able to learn this critical component of medical care for pregnant people. It makes me so sad to contemplate all that collective medical expertise leaving the state, all because our specialized area of practice—care that today we provide safely and routinely, when and where patients need it—would have become illegal.

92. Not knowing when or how the law will change makes it hard for PPMI to plan even a month in advance. For example, while we try to see people for their abortion appointments as soon as the patient is firm in their decision and available, at some of our health centers we must

schedule appointments two to three weeks in advance. If the Criminal Abortion Ban became enforceable next week, I would need guidance on whether that would prevent me from providing abortions entirely, whether it would only prohibit some of the procedures I provide, or something else entirely. In the absence of that clarity, I would have no idea whether I could care for the patients whose appointments are already scheduled for that week or the week after. And when other PPMI physicians and staff ask about the clinical schedule for the months ahead, I do not know what to tell them. I do not know whether we will still be able to provide abortion a month from now, because I do not know when or even whether the existing legal protections for abortion will disappear. Because it is my personal and professional mission to provide safe, compassionate, high-quality care to my patients, of which abortion is an essential part, this uncertainty keeps me up at night.

FURTHER AFFIANT SAYETH NAUGHT.

STATE OF MICHIGAN)
)ss
COUNTY OF WASHTENAW)

I declare that the above statements set forth in this affidavit are true to the best of my knowledge, information, and belief. If sworn as a witness, I can testify competently to the facts stated herein.

Sarah Wallett, M.D., M.P.H., FACOG

Subscribed and sworn before me this
5th day of April, 2022.

Signed: _____
Printed name: Betsy Lee Lewis, Notary Public
Ingham Co., MI, Acting in Washtenaw Co., MI
My Commission Expires: 01/23/2027

BETSY LEE LEWIS
Notary Public - State of Michigan
County of Ingham
My Commission Expires Jan 23, 2027
Acting in the County of Washtenaw