UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

PRETERM-CLEVELAND, INC., et al., **Plaintiffs,** **vs.** **LANCE HIMES, et al.,** **Defendants.**	:	**Case No. 1:18-cv-109** **Judge Susan J. Dlott** **PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION AND/OR MEMORANDUM IN SUPPORT**

MOTION

Pursuant to Fed. R. Civ. Pro. 65, Plaintiffs Preterm Cleveland Ohio, Planned Parenthood Southwest Ohio Region, Women's Med Group Professional Corporation, Roslyn Kade, M.D., and Planned Parenthood Greater Ohio, move for a temporary restraining order and preliminary injunction to declare unconstitutional Ohio House Bill 214 of the 132nd General Assembly ("H.B. 214" or "the Ban"), which will become effective on March 22, 2018. Plaintiffs also move to enjoin all Defendants; their officers, agents, servants, employees, and attorneys; and any persons in active concert or participation with them from enforcing or complying with H.B. 214. Plaintiffs request an injunction be issued on or before March 15, 2018 to provide time for an orderly transition in scheduling patients if the law were to take effect.

Plaintiffs have provided notice to Director Himes and will provide notice to all defendants today. However, due to the effective date of the Ban of March 22, 2018, an expedited briefing schedule, hearing, and ruling on the merits is requested.

Plaintiffs request that if a bond is required, it be set at $1.00.

MEMORANDUM IN SUPPORT

INTRODUCTION

Ohio House Bill 214 of the 132nd General Assembly ("H.B. 214" or "the Ban"), which prohibits "a person from performing, inducing, or attempting to perform or induce an abortion on a pregnant woman who is seeking the abortion because an unborn child has or may have Down Syndrome," does not provide support for parents raising children with Down syndrome. It does not allocate any state resources for education or care of individuals with Down syndrome throughout their lives, nor does it protect individuals with Down syndrome from discrimination in access to education, housing, or employment, to name just a few examples. Far from honoring the decisions of women and families who learn their fetus has Down syndrome--some of whom will decide to continue their pregnancies to term and parent, some of whom will place the child for adoption, and some of whom will decide to terminate their pregnancies--H.B. 214 takes the decisional authority away from women, in violation of the U.S. Constitution.

When a pregnant woman receives a diagnosis of Down syndrome, only she can decide how to proceed, along with her family, her pastor, her clinical team, and whomever else she involves in this intimate decision. Some women decide to continue the pregnancy, knowing that bringing a special needs child into the world is the right thing to do for them; others decide to terminate, knowing that that is the right decision given the needs of their existing children and other family members, their health, and a host of other factors that only they can weigh. Yet, H.B. 214 unconstitutionally bans abortions based on one's reason for seeking them, undermining women's right to make the best decision for themselves and their families.

Well-established constitutional limits, which ensure that a woman—not the state—is free to make the final decision regarding any previability abortion, apply regardless of what exceptions the ban may provide, and regardless of what interests the state may assert to justify it. The right to terminate a pregnancy prior to viability is a core principle of the constitutional protection afforded to women under the Fourteenth Amendment. The Ban plainly violates this core right and is thus *per se* unconstitutional.

STATEMENT OF FACTS

I. Abortion Practice and Safety

Approximately one in four women in this country will have an abortion in her lifetime. Lappen Dec. ¶ 10. Women seek abortions for a variety of health, familial, economic, and personal reasons. Lappen Dec. ¶ 12. Most women who have an abortion (nearly 60%) already have at least one child, and 66% plan to have children. Lappen Dec. ¶¶ 10, 12. Being forced to continue a pregnancy to term against her will can pose risks to a woman's physical, mental, and emotional health, and even to her life, as well as to the stability and wellbeing of her family, including existing children. Lappen Dec. ¶¶ 11, 12, 40, 41.

Plaintiffs are clinics and an individual physician who provide reproductive health services, including surgical abortion and medication abortion. Harvey Dec. ¶¶ 1-2; Kade Dec. ¶¶ 1-2; France Dec. ¶¶ 2-3. Plaintiffs provide medication abortion through 70 days LMP. Harvey Dec. ¶ 4; Kade Dec. ¶ 5; France Dec. ¶ 3. Medication abortion is a method of ending an early pregnancy by taking medications that cause the woman to undergo a process similar to an early miscarriage. Lappen Dec. ¶ 16. Surgical abortion, despite its name, is not a typical surgical procedure: it does not involve any incision. Lappen Dec. ¶

17. Surgical abortion is available in Ohio through 21 weeks, 6 days LMP, which is a previability point in pregnancy. Harvey Dec. ¶ 4; Kade Dec. ¶ 6; France Dec. ¶ 3. However, the overwhelming majority of abortions are performed during the first trimester of pregnancy, when the pregnancy is at or less than fourteen weeks LMP. Lappen Dec. ¶ 13.

Under Ohio law, a woman who wishes to have an abortion must visit the abortion provider at least 24 hours before the procedure will be performed. During that initial visit, she must receive certain information, as well as an ultrasound and the opportunity to see or hear the embryonic or fetal heart tone, and she must give her informed consent to the procedure. Ohio Rev. Code §§ 2317.56, 2919.12(A), 2919.191, 2919.192. Plaintiffs Preterm-Cleveland ("Preterm"), Planned Parenthood Southwest Ohio Region ("PPSWO"), Women's Med Group Professional Corporation ("WMGPC"), Planned Parenthood Greater Ohio ("PPGOH"), and Roslyn Kade, M.D. engage in non-directive patient education during the initial visit to ensure informed consent. That discussion is designed to make certain that patients are well-informed with respect to all of their options, including terminating the pregnancy; carrying the pregnancy to term and parenting; and carrying to term and placing the child for adoption. Harvey Dec. ¶ 7; Kade Dec. ¶ 7; France Dec. ¶ 9. In addition, the discussion is designed to ensure that the woman's choice is voluntary and not coerced. *Id*. Although some of Plaintiffs' patients disclose at least some information during this discussion about the reasons they are seeking an abortion, Plaintiffs do not require that patients disclose their reasons. Harvey Dec. ¶ 8; Kade Dec. ¶ 8.

Plaintiffs are aware that a small percentage of their patients seek abortions based on a prenatal diagnosis of or, in exceedingly rare cases, a test indicating, Down syndrome. Harvey Dec. ¶ 11; Kade Dec. ¶ 8; France Dec. ¶ 11. These patients typically come to the clinic only after undergoing extensive counseling with a high-risk obstetrician-gynecologist, also known as a specialist in Maternal-Fetal Medicine ("MFM"), and a genetic counselor. Harvey Dec. ¶¶ 9-10; Kade Dec. ¶ 9.

II. Down Syndrome

Down syndrome is the common name for a genetic anomaly, also known as Trisomy 21, that exists when an individual has an extra copy, whether full or partial, of the 21st chromosome. Lappen Dec. ¶ 20. There are various risk factors for Trisomy 21, such as advanced maternal age and having had a child with Down syndrome. *Id.* ¶ 21. The range of medical conditions and abilities can vary widely for people with Down syndrome, and many require significantly more care than individuals born without any such condition, sometimes stretching into adulthood. *Id.* ¶ 22.

There are various screening and diagnostic tests available to detect genetic, chromosomal, or structural anomalies, including Down syndrome. *Id.* ¶ 23. "Screening" tests cannot diagnose any particular anomaly, but rather indicate a likelihood or probability that one or more anomalies exist. *Id.* ¶ 24. These tests usually screen for a range of anomalies at the same time. *Id.* By contrast, "diagnostic" tests diagnose the existence or non-existence of particular anomalies with near certainty. *Id.*

The American College of Obstetricians and Gynecologists ("ACOG"), which is the preeminent professional association for OB/GYNs, recommends that all women should be counseled about prenatal genetic screening or diagnostic testing options as

early as possible in the pregnancy, ideally at the first prenatal visit. *Id.* ¶ 25. ACOG recommends that all women be offered the option of screening or diagnostic testing for fetal genetic disorders, regardless of the woman's age. *Id.* ACOG also recommends that women with positive screening test results be offered further counseling and diagnostic testing. *Id.*[1] For example, Dr. Lappen provides patients with further information regarding Down syndrome to inform and support their decision-making, including resources, referrals, and accurate, evidence-based information. *Id.* ¶ 34. He has referred patients both to medical professionals, including pediatricians and pediatric specialists, and to non-medical resources, including the National Down Syndrome Society and the National Down Syndrome Congress, as well as the Northeast-Ohio based organization Upside of Downs. *Id.*

There are multiple screening tests available during pregnancy. First trimester genetic screening is available from approximately 10 to 14 weeks LMP. *Id.* ¶ 26. One early test, called a nuchal translucency screening, consists of an ultrasound measurement of nuchal translucency (a fluid-filled space on the back of the fetal neck), combined with the measurement of two hormones from the woman's blood. *Id.* Another early screening test, available as early as 10 weeks LMP, is called a Non Invasive Prenatal Screening, or NIPS. *Id.* ¶ 27. Through a maternal blood test, NIPS evaluates fetal DNA that is found in the woman's blood. *Id.* NIPS is often combined with nuchal translucency screening in the first trimester. *Id.* The results of NIPS are usually available within 7 days. *Id.* Among other anomalies, these tests indicate the probability of Down syndrome. *Id.*

[1] Ohio law also requires that any patient receiving a prenatal or postnatal diagnosis of Down syndrome be provided with a state-created information sheet about Down syndrome. Ohio Rev. Code § 3701.69(B). Many patients receive counseling and information about Down syndrome beyond the minimum mandated by the state, however. Lappen Dec. ¶ 34.

In the second trimester, from 15 weeks LMP, a quadruple marker (or "quad") screening is available, which measures the levels of four different hormones in a woman's blood. *Id.* ¶ 26. These tests screen for Down syndrome, Trisomy 13, Trisomy 18, and anomalies of the brain and spinal cord. *Id.* Finally, an ultrasound examination to assess fetal anatomy is typically performed between 18 and 20 weeks and can often detect major physical anomalies in the brain and spine, skull, abdomen, heart, and limbs. *Id.*

There are two primary diagnostic tests that can confirm a diagnosis of Trisomy 21 or Down syndrome. The first is chorionic villus sampling (CVS), where a sample of cells is taken from the woman's placental tissue and analyzed. *Id.* ¶ 29. CVS is generally performed between 10 and 13 weeks LMP. *Id.* The diagnostic accuracy of CVS for chromosomal abnormalities is greater than 99%. *Id.* The second diagnostic test is amniocentesis. Amniocentesis involves using a needle to extract amniotic fluid from the gestational sac, which is then analyzed for genetic abnormalities. *Id.* ¶ 30. Amniocentesis is generally performed beginning at 15 weeks LMP. *Id.* The diagnostic accuracy of amniocentesis, like CVS, is greater than 99%. *Id.*

III. The Ban

H.B. 214 amends Section 3701.79 of the Revised Code and enacts Sections 2919.10 and 2919.101. Section 2919.10 prohibits any person from purposely performing or inducing or attempting to perform or induce an abortion if the person has knowledge that the pregnant woman is seeking the abortion, in whole or in part, because of any of the following reasons: (1) a test "indicating" Down syndrome; (2) a prenatal diagnosis of Down syndrome; or (3) "any other reason to believe" the fetus has Down syndrome. Ohio

Rev. Code § 2919.10(B) ("the Ban").[2] Violation of the Ban constitutes a fourth-degree felony. *Id.* at § 2919.10(C). In addition, the Ban requires the state medical board to revoke the license of a physician who violates it, *id.* at § 2919.10(D) and makes that physician liable in a civil action for compensatory and exemplary damages to "any person, or the representative of the estate of any person, who sustains injury, death, or loss to person or property" as the result of an abortion or attempted abortion prohibited under the Ban, *id.* at § 2919.10(E). The Ban contains no exception to its criminal or other sanctions if the abortion is necessary to preserve the life or health of the woman.

The Ban also requires the physician to attest in writing that he or she is not aware that fetal Down syndrome is a reason for the woman's decision to terminate her pregnancy. Section 2919.101 states: "In the abortion report required under section 3701.79 of the Revised Code, the attending physician shall indicate that the attending physician does not have knowledge that the pregnant woman was seeking the abortion, in whole or in part," for any of the reasons enumerated above. *Id.* at § 2919.101(A) (emphasis added). Similarly, as amended, section 3701.79(C) provides that, "insofar as the patient makes the data available that is not within the physician's knowledge," each abortion report shall include "[w]ritten acknowledgment by the attending physician that the pregnant woman is not seeking the abortion, in whole or in part," because of any of the reasons enumerated above. *Id.* at § 3701.79(C)(7) (emphasis added). Under Ohio law, when establishing an element of a criminal offense, knowledge is present when a person "is aware that [the relevant] circumstances probably exist," or "if a person subjectively

[2] The provision defines "Down syndrome" as a "chromosome disorder associated either with an extra chromosome twenty-one, in whole or in part, or an effective trisomy for chromosome twenty-one." *Id.* at 2910.10(A)(1).

believes that there is a high probability of [the circumstance's] existence and fails to make inquiry or acts with a conscious purpose to avoid learning the fact." O.R.C. § 2901.22 (B). Finally, the Ban requires the department of health to adopt rules "to assist in compliance with" section 2919.101 within 90 days of its effective date. *Id.* at § 2919.101(B).

ARGUMENT

The standard for evaluating a request for a temporary restraining order or preliminary injunction under Rule 65 is well established in this Circuit. Though there is no "rigid and comprehensive test" for determining the appropriateness of this relief, *Tate v. Frey*, 735 F.2d 986, 990 (6th Cir. 1984), the Court should consider the following four factors: (1) whether the party seeking the injunction has shown a substantial likelihood of success on the merits; (2) whether the party seeking the injunction will suffer irreparable harm absent the injunction; (3) whether the injunction will cause others to suffer substantial harm; and (4) whether the public interest would be served by the preliminary injunction. *Doe v. Barron*, 92 F. Supp. 2d 694, 695 (S.D. Ohio 1999); *Memphis Planned Parenthood, Inc. v. Sundquist*, 175 F.3d 456, 460 (6th Cir. 1999); *S. Milk Sales, Inc. v. Martin*, 924 F.2d 98, 103 n.3 (6th Cir. 1991); *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1059 (S.D. Ohio 1995), *aff'd*, 130 F.3d 187 (6th Cir. 1997).

These factors are "to be balanced and [are] not prerequisites that must be satisfied." *McPherson v. Mich. High Sch. Athletic Ass'n*, 119 F.3d 453, 459 (6th Cir. 1997) (en banc) (citation omitted). "[T]hey are not meant to be rigid and unbending requirements." *Id.* The "plaintiff must show more than a mere possibility of success," but

need not "prove his case in full." *Certified Restoration Dry Cleaning Network, L.L.C. v. Tenke Corp*., 511 F.3d 535, 543 (6th Cir. 2007) (citations omitted).

Here, as set forth below and in the accompanying declarations, Plaintiffs easily meet the test for a temporary restraining order or preliminary injunctive relief. Because the Ban conflicts with more than four decades of unwavering Supreme Court precedent, Plaintiffs are extremely likely to succeed on the merits of their substantive due process claim. Further, the Ban would irreparably harm Plaintiffs and their patients, and the balance of hardships and the public interest strongly favor the issuance of a temporary restraining order or preliminary injunction.

I. Plaintiffs Are Likely to Succeed on the Merits of Their Claim Because H.B. 214 Is a Blatantly Unconstitutional Ban on Previability Abortions.

H.B. 214 constitutes a clear violation of the Fourteenth Amendment under long-standing and unquestioned Supreme Court precedent because it bans abortions based solely on women's reason for seeking them. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 879 (1992). This violates the categorical rule that every woman must be allowed to make her own final decision whether to terminate her pregnancy before the fetus attains viability. *Id.* Moreover, while it is unnecessary to apply the undue burden test to a previability ban such as H.B. 214, *see Isaacson v. Horne*, 716 F.3d 1213, 1226 (9th Cir. 2013) (explaining that it is a "bright-line rule that the state may not proscribe abortion before viability," and courts need not apply the "undue burden" standard to previability bans), there is no question that H.B. 214 fails that test because it poses a substantial—indeed, insurmountable—obstacle to the ability of certain women to obtain a previability abortion. Accordingly, Plaintiffs are likely to succeed on the merits of their claim that H.B. 214 is an unconstitutional ban on previability abortions.

A. Any Ban on Previability Abortions Is Per Se Unconstitutional Under Binding and Unquestioned Supreme Court Precedent.

The U.S. Supreme Court has repeatedly and unequivocally held that, under the Due Process Clause of the Fourteenth Amendment, a state many not ban abortion prior to viability. *See, e.g.*, *Whole Woman's Health v. Hellerstedt*, ---U.S.----, 136 S. Ct. 2292, 2299 (2016) (reaffirming that a provision of law is constitutionally invalid if it bans abortion "before the fetus attains viability" (quoting *Casey*, 505 U.S. at 878)). Indeed, the Supreme Court stated in *Planned Parenthood v. Casey*, "The woman's right to terminate her pregnancy before viability is the most central principle of *Roe v. Wade*. It is a rule of law and a component of liberty we cannot renounce." *Casey*, 505 U.S. at 871; *Roe v. Wade*, 410 U.S. 113, 163–64 (1973); *accord Isaacson*, 716 F.3d at 1217, 1221 (stating that the U.S. Supreme Court has been "unalterably clear regarding one basic point": "a woman has a constitutional right to choose to terminate her pregnancy before the fetus is viable"); *Women's Med. Prof'l Corp. v. Voinovich*, 130 F.3d 187, 192 (6th Cir. 1997) (explaining that *Casey* "reaffirmed this 'central holding' of *Roe,* which mandates that a State may not prohibit a woman from making the ultimate decision to terminate her pregnancy prior to viability" (quoting 505 U.S. at 879)).

The Supreme Court's decisions rest on the fundamental right of every woman to determine the course of her pregnancy before viability, "because . . . [her] liberty . . . is at stake in a sense unique to the human condition and so unique to the law. The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear." *Casey, 505 U.S.* at 852. Recognizing "the urgent claims of the woman to retain the ultimate control over her destiny and her body, claims implicit in the meaning

of liberty," the Court "conclude[d] the line should be drawn at viability, so that before that time the woman has a right to choose to terminate her pregnancy." *Id.* at 869-70.

Underlying the privacy right first recognized in *Roe* and reaffirmed in *Casey* and *Whole Woman's Health* is the principle that the state may not dictate appropriate reasons for a woman's decision to terminate a pregnancy, nor may it commandeer her deliberative process. *Roe* explicitly held that it was the woman's "decision" that merited Fourteenth Amendment protection, and that she must be permitted to engage in consultation with her physician to make that decision. *Roe*, 410 U.S. at 153. Extending further this understanding of the woman's decisional autonomy, *Casey* explained that protection for the abortion right reflects the fact that "[a]t the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State." *Casey*, 505 U.S. at 851 (1992); *see also Planned Parenthood of Indiana, Inc. v. Comm'r of Indiana State Dep't Health*, 699 F.3d 962, 987 (7th Cir. 2012) (noting that the abortion right is, in part, "a constitutionally protected interest 'in making certain kinds of important decisions' free from governmental compulsion" (quoting *Maher v. Roe,* 432 U.S. 464, 473 (1977) (quoting *Whalen v. Roe*, 429 U.S. 589, 599–600 & nn. 24 & 26 (1977))). The State, in other words, has no right to stand in judgment of the woman's decision or of her reasons for that decision.

A ban on abortion at any point prior to viability, whether partial or total, is therefore *per se* unconstitutional, no matter what interests the state asserts to support it. "Before viability, the State's interests are not strong enough to support a prohibition of

abortion. . . . Regardless of whether exceptions are made for particular circumstances, a State may not prohibit *any* woman from making the ultimate decision to terminate her pregnancy before viability." *Casey*, 505 U.S. at 846, 879 (emphasis added). Given this unwavering line of Supreme Court precedent, since *Roe*, every federal appellate court or state high court to consider the question has ruled that a ban on abortions before viability, with or without exceptions, violates the Fourteenth Amendment.[3]

Indeed, the federal district court in Indiana recently held unconstitutional a law similar to the one at issue here, which prohibited abortion if sought solely on the basis of, *inter alia*, a prenatal diagnosis of Down syndrome. As that court explained, "[t]he woman's right to choose to terminate a pregnancy pre-viability is categorical." *Planned Parenthood of Indiana & Kentucky, Inc.* ("*PPINK*") *v. Comm'r, Indiana State Dep't of Health*, 265 F. Supp. 3d 859, 866 (S.D. Ind. 2017) (citing *Casey*, 505 U.S. at 879). That court continued:

> For this Court to hold such a law constitutional would require it to recognize an exception where none have previously been recognized. Indeed, the State has not cited a single case where a court has recognized an exception to the Supreme Court's categorical rule that a woman can choose to terminate a pregnancy before viability. This is unsurprising given that it is a woman's right to *choose* an abortion that is protected, which, of course, leaves no

[3] *See, e.g.*, *MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768, 773 (8th Cir. 2015) (striking down ban on previability abortions with exceptions), *cert. denied*, 136 S. Ct. 981 (2016); *Edwards v. Beck*, 786 F.3d 1113, 1117 (8th Cir. 2015) (same), *cert. denied*, 136 S. Ct. 895 (2016); *Isaacson v. Horne*, 716 F.3d 1213, 1217, 1231 (9th Cir. 2013) (same), *cert. denied*, 134 S. Ct. 905 (2014); *Jane L. v. Bangerter*, 102 F.3d 1112, 1117−18 (10th Cir. 1996) (same), *cert. denied*, 520 U.S. 1274 (1997); *Sojourner T. v. Edwards*, 974 F.2d 27, 31 (5th Cir. 1992) (same), *cert. denied*, 507 U.S. 972 (1993); *Guam Soc'y of Obstetricians & Gynecologists v. Ada*, 962 F.2d 1366, 1369 (9th Cir. 1992) (same), *cert. denied*, 506 U.S. 1011 (1992); *DesJarlais v. State, Office of Lieutenant Governor*, 300 P.3d 900, 904–05 (Alaska 2013) (invalidating proposed previability ban on all abortions with exception for "necessity"), *reh'g denied*; *In re Initiative Petition No. 395, State Question No. 761*, 286 P.3d 637, 637−38 (Okla. 2012) (invalidating proposed definition of a fertilized egg as a "person" under due process clause), *cert. denied*, 133 S. Ct. 528 (2012); *Wyo. Nat'l Abortion Rights Action League v. Karpan*, 881 P.2d 281, 287 (Wyo. 1994) (ruling proposed ban on abortions would be unconstitutional); *In re Initiative Petition No. 349, State Question No. 642*, 838 P.2d 1, 7 (Okla. 1992) (striking down proposed abortion ban with exceptions), *cert. denied*, 506 U.S. 1071 (1993).

> room for the State to examine, let alone prohibit, the basis or bases upon which a woman makes her choice.

Id. at 867 (citing *Casey*, 505 U.S. at 846, 879).

In sum, the Supreme Court has squarely rejected the claim that any State interest, including its interest in potential life—no matter what variant of that interest is put forward—can justify a ban on abortion prior to viability. The Supreme Court has already "struck a balance" between the State's interests in regulating or restricting abortion and a woman's liberty interests in obtaining an abortion and has "concluded that, prior to viability, the woman's right trumps the State's interest[s]." *PPINK*, 265 F. Supp.3d at 867. Any claims by the State as to the number or strength of the interests it asserts simply cannot change this inevitable result. To hold otherwise would require this Court to overrule the central holdings of *Roe* and *Casey*, which of course it cannot do. *See MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768, 772 (8th Cir. 2015) ("[t]he [Supreme Court] has yet to overrule the *Roe* and *Casey* line of cases," and thus all federal courts "are bound by those decisions").

B. H.B. 214 Imposes an Undue Burden on the Right to Seek an Abortion Before Viability.

As the Ninth Circuit has recognized, the undue burden "mode of analysis has no place where, as here, the state is *forbidding* certain women from choosing pre-viability abortions rather than specifying the conditions under which such abortions are to be allowed." *Isaacson*, 716 F.3d at 1225 (emphasis in original). Thus, only laws that *regulate* the performance of abortions, but do not *prohibit* them outright, are evaluated under the undue burden test. 505 U.S. at 878 ("An undue burden exists, and therefore a provision of law is invalid, if its purpose or effect is to place a substantial obstacle in the

path of a woman seeking an abortion before the fetus attains viability."). The state may use its regulatory authority if and only if such actions do not "strike at the right itself." *Gonzales v. Carhart*, 550 U.S. 124, 157–158 (2007); *see also id.* at 145 ("Before viability, the State's interests are not strong enough to support a prohibition of abortion *or* the imposition of a substantial obstacle to the woman's effective right to elect the procedure.") (emphasis added).

Nonetheless, even applying the undue burden test, H.B. 214 is patently unconstitutional. It has the unmistakable purpose and effect of imposing a substantial obstacle in the path of certain women seeking previability abortions. As the Supreme Court has instructed, a court evaluating whether a law constitutes an undue burden must consider its effect only on those women "for whom the law is a restriction, not the group for whom the law is irrelevant." *Casey*, 505 U.S. at 894. Here, for a woman choosing abortion due, in whole or in part, to a Down syndrome diagnosis or indication, the law is not only a substantial obstacle to her "right to make the ultimate decision" about her pregnancy prior to viability, but an absolute one. *Id.* at 877. In other words, it would prevent all women for whom it is relevant from obtaining a previability abortion. *See, e.g.*, *Jane L. v. Bangerter*, 102 F.3d 1112, 1117–18 (10th Cir. 1996) (holding that a ban on abortions after 20 weeks, with limited exceptions, had "both the purpose and effect of placing a substantial obstacle in the path of a woman seeking to abort a nonviable fetus" and was therefore unconstitutional). Moreover, no state interest is constitutionally sufficient to outweigh a burden that constitutes a complete obstacle to a woman's previability abortion decision. *See Whole Woman's Health*, 136 S. Ct. at 2309 (holding that *Casey* "requires that courts consider the burdens a law imposes on abortion access

together with the benefits those laws confer"). Therefore, H.B. 214 is necessarily unconstitutional.

The blatant unconstitutionality of H.B. 214 is only aggravated by the fact that it contains no exception allowing an abortion to proceed if a woman's health or life is at risk. If one reason for the woman's abortion decision is a diagnosis or other test indicative of Down syndrome, she is forbidden to proceed—even if continuing the pregnancy would endanger her life or health. The principle that the woman retains the right to seek an abortion if the procedure is necessary to protect her life or her health, which was first articulated in *Roe*, 410 U.S. at 163-164, has never been questioned by the U.S. Supreme Court, *see also Casey*, 505 U.S. at 880 (noting that "the essential holding of *Roe* forbids a State to interfere with a woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health"). In forcing a woman to continue a pregnancy that endangers her life or health when (and only when) a Down syndrome diagnosis also provides a reason for the abortion, H.B. 214 violates a clear constitutional proscription.

II. Enforcement of the Ban Will Inflict Irreparable Harm on Plaintiffs' Patients.

In the absence of a preliminary injunction, Plaintiffs and their patients will suffer irreparable harm. First, the law directly violates Plaintiffs' patients' constitutional right to abortion, which constitutes *per se* irreparable harm. *See, e.g.*, *Bonnell v. Lorenzo*, 241 F.3d 800, 809 (6th Cir. 2001) ("[W]hen reviewing a motion for a preliminary injunction, if it is found that a constitutional right is being threatened or impaired, a finding of irreparable injury is mandated." (citing *Elrod v. Burns*, 427 U.S. 347, 373 (1976)); *Planned Parenthood Ass'n of Cincinnati, Inc. v. City of Cincinnati*, 822 F.2d 1390, 1400

(6th Cir. 1987) (finding irreparable injury where plaintiff has shown substantial likelihood of success on merits of constitutional challenge to abortion regulation); *see also Planned Parenthood Sw. Ohio Region v. Hodges*, 138 F. Supp. 3d 948, 960 (S.D. Ohio 2015).

Second, the Ban will cause Plaintiffs' patients other irreparable, tangible injuries, as well. Some women will be unable to travel out of state for an abortion--for example, due to financial or other constraints--and will thus be forced to carry a pregnancy to term against their will. *See* Harvey Dec. ¶ 12; Kade Dec. ¶ 11; France Dec. ¶ 12; *Roe*, 410 U.S. at 153 ("The detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it."); *Deerfield Med. Ctr. v. City of Deerfield Beach*, 661 F.2d 328, 338 (5th Cir. Unit B Nov. 1981) (an infringement on a woman's constitutional right to have an abortion "mandates" a finding of irreparable injury because "once an infringement has occurred it cannot be undone by monetary relief").

Even those women who are able to travel long distances to access abortion outside of Ohio will face unnecessary and harmful delays. Kade Dec. ¶ 11. These threats to Plaintiffs' patients' health and wellbeing also constitute irreparable harm. *See, e.g.*, *Harris v. Bd. of Supervisors, L.A. Cnty.*, 366 F.3d 754, 766 (9th Cir. 2004) (holding

likelihood of irreparable harm established where evidence showed pain, complications, and other adverse effects due to delayed medical treatment); *Planned Parenthood of Wisconsin, Inc. v. Van Hollen I*, 963 F. Supp. 2d 858, 868 (W.D. Wisc. 2013) (holding that an abortion restriction caused irreparable harm to patients by causing an undue travel burden and by imposing increased health risks through delay).

Finally, as the evidence demonstrates, some women with high-risk pregnancies have complications that lead them to end their pregnancies to preserve their lives or health. Lappen Dec. ¶ 39-40. There are numerous conditions that pose a substantial mortality risk in pregnancy, including pulmonary hypertension and maternal cardiac disease, some with mortality risks as high as 50%. Lappen Dec. ¶ 41. In some percentage of these cases, there is also an (unrelated) prenatal diagnosis of Down syndrome. Lappen Dec. ¶ 40. The Ban thus threatens significant harm to the health of women whose medically complicated pregnancy is accompanied by a diagnosis of fetal Down syndrome.

III. An Injunction That Maintains the Status Quo Will Not Cause Harm to Others and Will Serve the Public Interest.

In contrast to the irreparable harm the Ban will inflict on women seeking abortions in Ohio, a temporary restraining order or preliminary injunction that merely preserves the status quo – more than four decades of access to previability abortions – will not impose any harm on Defendants or anyone else. "The public interest in preserving the status quo and in ensuring access to the constitutionally protected health care services while this case proceeds is strong." *Planned Parenthood Sw. Ohio Region*, 138 F. Supp.3d at 961; *see also Doe v. Barron*, 92 F. Supp. 2d 694, 697 (S.D. Ohio 1999) ("A woman's right to choose to terminate her pregnancy was decided [decades] ago in

Roe v. Wade. It is in the public's interest to uphold that right when it is being arbitrarily [or unconstitutionally] denied."). Indeed, the public interest is always served "by the robust enforcement of constitutional rights." *Am. Freedom Def. Initiative v. Suburban Mobility Auth. for Reg'l Transp.*, 698 F.3d 885, 896 (6th Cir. 2012); *see also Planned Parenthood Ass'n of Cincinnati Inc.*, 822 F.2d at 1400 (holding that there was no substantial harm in preventing the enforcement of an ordinance that was likely unconstitutional).

CONCLUSION

For the foregoing reasons, Plaintiffs request that this Court grant their motion for a temporary restraining order and/or a preliminary injunction.

Respectfully submitted,

/s/ B. Jessie Hill

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CERTIFICATE OF SERVICE

I hereby certify that on February 15, 2018, a copy of the foregoing pleading was filed electronically. Notice of this filing will be sent to all parties for whom counsel has entered an appearance by operation of the Court's electronic filing system. Parties may access this filing through the Court's system. I further certify that a copy of the foregoing pleading and the Notice of Electronic Filing has been served by ordinary U.S. mail and email upon all parties for whom counsel has not yet entered an appearance electronically, including:

/s/Jennifer L. Branch
Attorney for Plaintiff

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

PRETERM-CLEVELAND, INC., et al.,	:	**Case No. 1:18-cv-109**
Plaintiffs,	:	**Judge Susan J. Dlott**
vs.	:	
LANCE HIMES, et al.,	:	**DECLARATION OF JUSTIN LAPPEN, M.D., F.A.C.O.G., IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION**
Defendants.	:	

I, Justin Lappen, pursuant to 28 U.S.C. §1746, declare under penalty of perjury that the following is true and correct:

1. I am a maternal-fetal medicine specialist ("MFM") and a board-certified obstetrician-gynecologist ("OB/GYN").

2. I earned my medical degree at Johns Hopkins University in 2006, completed my residency training at the McGaw Medical Center of Northwestern University from 2006 to 2010, and completed my fellowship in Maternal-Fetal Medicine at MetroHealth Medical Center of Case Western Reserve University in 2017. I am also a fellow of the American College of Obstetricians and Gynecologists ("ACOG").

3. As an MFM, I specialize in the management of high-risk pregnancies. A specialization in maternal-fetal medicine requires an extra three years of training, beyond the standard residency period for an OB/GYN. My goal as an MFM is to help women and families through challenging

pregnancies—pregnancies that may be complicated by advanced maternal age, a medical condition, a fetal anomaly diagnosis, or more than one of these.

4. I am also an assistant professor of obstetrics and gynecology and of family medicine at the Case Western Reserve University School of Medicine. I have served as Associate Residency Program Director in Obstetrics and Gynecology and Assistant Director of a Ryan Residency Training Program in Family Planning. Additionally, I have served as Director of a Fellowship in Advanced Obstetrics in the Department of Family Medicine. Since 2010, I have trained hundreds of medical students, residents, and fellows.

5. I am actively engaged in research and have authored 26 manuscripts published in peer-reviewed journals, 29 presentations at national meetings, and 7 book chapters. I have participated in national consensus panels including the National Partnership for Maternal Safety committee on Vital Sign Triggers, a group sponsored by ACOG and the Society for Maternal Fetal Medicine ("SMFM") to reduce preventable maternal morbidity and mortality in the United States.

6. In addition to my hospital practice, I also perform abortions at Preterm up to 21 weeks, 6 days after the woman's last menstrual period ("LMP") (which is the same as 20 weeks postfertilization), a point in pregnancy that is prior to viability. I have worked at Preterm since 2010. I am therefore familiar with Preterm's services and patients. I have attached my curriculum vitae summarizing my educational and professional background and qualifications.

7. I have read the text of H.B. 214, which is set to go into effect on March 23, 2018. It is an affront to Ohio women and families.

8. When a woman receives a diagnosis of Down syndrome or another fetal anomaly, only she can decide how to proceed, along with her family, her pastor, her clinical team – whomever

she involves in this intimate decision process. Some women decide to continue the pregnancy, knowing that it is the right thing to do for them; others decide to terminate, knowing that that is the right decision given their lives, the needs of their existing children and other family members, their health, and a host of other factors that only they can weigh. My job is to inform, care for, and support my patients and their families, whatever decision they make. That means ensuring that my patients who decide to parent children with Down syndrome have the information and support they need to make this very personal and important decision. It also means ensuring that my patients who decide to terminate have access to the highest quality abortion care.

Facts about abortion

9. As a result of my study, training, and years of clinical experience, including my clinical practice at Preterm, I am familiar with the following facts and statistics about abortion.

10. Abortion is one of the most common medical procedures performed in the United States today. Approximately one quarter of the women in this country will have an abortion by age forty-five. Of those women, a majority (61%) have at least one child, and most (66%) plan to have a child or children in the future.

11. Abortion is virtually always safer than carrying a pregnancy to term. A woman is ten times more likely to die from carrying a pregnancy to term than from a first trimester abortion.

12. Women seek abortion for a variety of reasons, including familial, medical, and financial. For example, some women make the decision to terminate a pregnancy because it is not the right time in their lives to have a child or to increase the size of their families. Some women choose abortion because they have an underlying health condition that is caused by or exacerbated by continuing a pregnancy. Some may decide to end a pregnancy because it is the result of rape or

incest. Some women terminate a pregnancy after receiving a pre-natal diagnosis of fetal anomaly.

13. Most abortions are performed during the first trimester of pregnancy, at or before 14 weeks LMP; nearly 90% are performed in the first twelve weeks.

14. Many women who have abortions after the first trimester do so because of obstacles that prevented them from seeking the abortion earlier, such as financial difficulties and trouble accessing an abortion clinic. Others receive a fetal diagnosis that is not available until later in the pregnancy.

15. Women in Ohio may choose from two different types of abortion procedures: medication abortion and surgical abortion.

16. Medication abortion involves taking medications that cause the woman to undergo a process similar to an early miscarriage. In Ohio, medication abortion is available up to 70 days (10 weeks) LMP.

17. Surgical abortion, despite its name, is not a typical surgical procedure: it does not involve any incision. Rather, surgical abortion involves utilizing instruments to remove the products of conception from the uterus. In Ohio, surgical abortion may be legally performed until 21 weeks, 6 days LMP, which is the same as 20 weeks post-fertilization.

Facts about Down syndrome and Down syndrome Testing

18. In my MFM practice, I regularly counsel pregnant women about genetic and other fetal anomalies.

19. As a result of my training and practice in the field of maternal-fetal medicine, I am familiar with the following facts about Down syndrome and methods of testing for Down syndrome.

20. Down syndrome is the common name for a genetic anomaly, also known as Trisomy 21, that results from a trisomy—that is, an extra copy, whether full or partial—of the twenty-first chromosome.

21. There are various risk factors for Trisomy 21, such as advanced maternal age and having had a child with Down syndrome. But because Trisomy 21 results from a genetic event at the time of conception, there is no way to predict in advance of pregnancy whether a particular individual will have a fetus with Down syndrome.

22. Individuals born with Down syndrome may have a range of intellectual disabilities and medical conditions and therefore may require significant care stretching into adulthood. Individuals with Down syndrome may have one or more of the following medical conditions, and the severity of the conditions varies between individuals: intellectual disability; behavioral and/or psychiatric disorders that may interfere with function at home or school, congenital heart disease that requires one or more surgeries to repair, gastrointestinal disorders that may require surgical correction, hearing loss, endocrine disorders including diabetes and hypothyroidism, and bone and joint disorders including hip dislocation and instability of the cervical spine that may result in spinal cord compression. Given these associated medical conditions, individuals with Down syndrome require an organized, often multidisciplinary approach to care that extends from birth into adulthood. Testing during pregnancy cannot reveal whether a particular instance of Down syndrome will be severe or mild.

23. There are various screening and diagnostic tests available to determine the presence of any genetic, chromosomal, or structural anomalies, including Down syndrome. The typical approach to genetic screening in pregnancy includes the assessment for common fetal

aneuploidies—that is, an abnormal number of chromosomes—including Trisomy 21 (Down Syndrome), Trisomy 13, Trisomy 18, and aneuploidy involving the sex chromosomes (X and Y).

24. Screening tests cannot diagnose any particular anomaly, but rather indicate a likelihood or probability that one or more anomalies exist. These tests usually screen for a range of anomalies at the same time and may indicate a likelihood of more than one anomaly at once. By contrast, diagnostic tests diagnose the existence or non-existence of particular anomalies with near certainty.

25. ACOG, which is the preeminent professional association for OB/GYNs, recommends that all women should be counseled about prenatal genetic screening and diagnostic testing options as early as possible in the pregnancy, ideally at the first prenatal visit. ACOG recommends that all women, regardless of age, be offered the option of aneuploidy screening or diagnostic testing for fetal genetic disorders. ACOG also recommends that women with positive screening test results be offered further counseling and diagnostic testing.

26. There are multiple screening tests for aneuploidy used in pregnancy. First trimester genetic screening is available from 10 weeks 0 days to 13 weeks 6 days LMP and consists of an ultrasound measurement of nuchal translucency (a fluid-filled space on the back of the fetal neck) and the measurement of two hormones from the woman's blood. In the second trimester from 15 weeks 0 days LMP, a quadruple marker (or "quad") screening is available, which measures the levels of four different hormones in a woman's blood. These tests screen for Down syndrome, Trisomy 13, Trisomy 18, and anomalies of the brain or spinal cord. An additional screening test is an ultrasound examination. An ultrasound examination to assess the fetal anatomy is typically performed between 18 weeks and 20 weeks LMP and can often detect major physical anomalies in the brain and spine, skull, abdomen, heart, and limbs.

27. Another early screening test is a Non Invasive Prenatal Screening, or NIPS. Through a test of the woman's blood, NIPS evaluates cell free DNA in her circulation. Fetal cell free DNA can be isolated from her DNA as a mechanism to screen for genetic conditions or aneuploidy. NIPS is often combined with nuchal translucency screening in the first trimester. NIPS can be performed as early as 10 weeks LMP, and results are usually available within 7 days. Among other anomalies, the NIPS results indicate the probability of Trisomy 21.

28. If the screening indicates an increased probability of a fetal genetic condition or aneuploidy, it is my practice to offer patients a diagnostic test to confirm whether the anomaly that the screening test indicated is present. I also offer those patients counseling to help them understand the meaning of the screening test and to inform them of the risks and benefits of proceeding to a diagnostic test. This is consistent with the standard of care in my field and with ACOG guidelines.

29. There are two primary diagnostic tests that can confirm a diagnosis of Trisomy 21 or Down syndrome. The first is chorionic villus sampling (CVS), where a sample of cells is taken from the woman's placental tissue and analyzed. CVS is generally performed between ten and thirteen weeks LMP. The diagnostic accuracy of CVS for aneuploidy is greater than 99%.

30. The second diagnostic test is amniocentesis. Amniocentesis involves using a needle to extract amniotic fluid from the gestational sac, which is then analyzed for genetic abnormalities. Amniocentesis is generally performed beginning at 15 weeks gestation. The diagnostic accuracy of amniocentesis for aneuploidy is greater than 99%.

31. Many women will not receive a confirmed diagnosis of Down syndrome until well into the second trimester of pregnancy because amniocentesis, which tests for a wider range of conditions and is more widely available than CVS, is not available until 15 weeks LMP.

32. Although the available diagnostic tests provide a high level of certainty as to whether Down syndrome is present, there is no way to know before birth whether the Down syndrome will be mild, severe, or somewhere in between.

33. If the diagnostic test indicates Down syndrome (or another anomaly), the woman is again offered counseling to help her understand the condition and carefully consider her options, including whether to continue with the pregnancy.

34. When a patient is faced with an unanticipated screening result or diagnosis, including Down syndrome, my purpose is to provide comprehensive, objective, and individualized counseling to ensure she makes a well-informed and autonomous decision that is best for her and her family. In these challenging situations, I provide objective, compassionate, and non-directive counseling about options, including pregnancy continuation and termination, and I help women and their families navigate an unexpected and what may be a profoundly difficult situation. I provide patients with information that may help guide their decision-making, including resources regarding the specific diagnosis (which may include referrals to pediatric specialists, and advocacy or patient groups) and accurate, evidence-based information on pregnancy termination. If a patient is interested in gathering additional information, I typically refer her first to medical professionals—pediatricians and pediatric specialists. I also point her to non-medical resources including the National Down Syndrome Society and the National Down Syndrome Congress, as well as the Upside of Downs (which is a Northeast-Ohio based group). All of these organizations have excellent and informative websites and additional resources for patients seeking further information. This counseling complies with—and exceeds the minimum requirements of—Ohio law (Ohio Rev. Code § 3701.69(B)), which prescribes particular information that I must provide to patients who receive a prenatal or postnatal diagnosis of Down

syndrome. Importantly, I allow the patient's values, desires, and questions to guide our conversations.

Impact of H.B. 214 on My Patients

35. Providing ethical abortion care requires that I ensure my patients' decisions are informed and voluntary. In my experience, the overwhelming majority of my patients have arrived firmly at their decision for abortion after careful consideration of their options and what is best for their life, family, and circumstances, and so they are resolute in their decision. During my conversations with patients before, during or after abortion, some volunteer the reasons why they have pursued abortion and others do not. However, I do not ask them about the specifics of their path leading to their ultimate decision to pursue abortion. My primary responsibility is to assess for any lack of resolve or coercion, as I would not proceed with an abortion for any woman who is not certain of her decision or is being forced into it. I communicate with all of my patients that I am available to discuss any details of their decision if desired.

36. I am aware of a minority of my patients at Preterm who have terminated pregnancies after receiving a diagnosis of Down syndrome. (I cannot recall treating any patient who terminated a pregnancy based on a screening test alone.) This assertion is based, in part, on my conversations with patients, but for some patients may also be based on my review of their medical records. While it is not medically relevant for me to know whether there has been a Down syndrome diagnosis or screen in order to perform the procedure safely, we take a detailed medical history from patients prior to the procedure, and many will disclose the diagnosis during this time. In addition, most patients who come to Preterm for an abortion after a diagnosis are referred to us from another facility in Cleveland, somewhere else in Ohio, or even out of state, and this fact will usually be indicated in the patient's chart. These patients carrying pregnancies

with fetal anomalies typically come to Preterm only after undergoing extensive counseling with a specialist in Maternal-Fetal Medicine and a genetic counselor.

37. In my experience, which includes counseling women and families who receive diagnoses of various anomalies and providing care both for those who choose termination and for those who choose continuation of pregnancy, I do not feel it is possible (or appropriate) to generalize about the reasons underlying any woman's decision. The decision to terminate a pregnancy is motivated by diverse, complex, and interrelated factors that are intimately related to the individual woman's values and beliefs, culture and religion, health status and reproductive history, and resources and economic stability. In my experience, women make careful decisions that are most acceptable for their lives, families, and circumstances. The ability to make an informed and autonomous choice is of paramount importance, one that allows any individual woman to best direct her life in the present and future.

38. I am concerned that H.B. 214 will encourage women who have had Down syndrome testing and decide to proceed with an abortion to hide the test results from the physician and staff who will provide the abortion. This could have negative consequences for women who may prefer to discuss their reasons during the patient education session or who may wish to discuss the results with the physician who will perform the abortion.

39. As a Maternal-Fetal Medicine specialist, I also see many women with high-risk pregnancies. A "high-risk pregnancy" is one in which, because of advanced maternal age or a medical condition, there is an elevated risk of pregnancy complications and of resulting harm to the woman or the fetus.

40. Some women with high-risk pregnancies end up having complications that require an abortion in order to preserve their life or health. In some percentage of these cases, there is also a diagnosis of fetal Down syndrome.

41. There are numerous diagnoses that pose a substantial mortality risk in pregnancy, including pulmonary hypertension, maternal cardiac disease (cardiomyopathy, Eisenmenger's syndrome, or other congenital heart disease), or autoimmune diseases (lupus with nephritis or autoimmune hepatitis with cirrhosis). These are conditions that have mortality risks as high as 50% or have risks for progressive organ failure in pregnancy that could result in the need for transplantation.

42. The risk of fetal Down syndrome is independent of a woman's underlying medical conditions.

43. As I understand the meaning of H.B. 214, there is no exception allowing an abortion to proceed when it is necessary to preserve the life or health of the woman, if the Down syndrome diagnosis is also a reason for terminating the pregnancy. Therefore, if H.B. 214 goes into effect, I will be unable to provide an abortion necessary to preserve my patient's health if fetal Down syndrome is also a reason for her abortion.

44. If H.B. 214 goes into effect, I will be unable to provide abortion care to any woman who I know is seeking the abortion in part because of a screening test indicating Down syndrome, a diagnosis of Down syndrome, or any other reason to believe there is fetal Down syndrome. Instead, I will counsel her to travel out of the state, if possible, to have an abortion if desired. I believe that some of those women will ultimately be unable to obtain an abortion—for example, because they are unable to procure sufficient funds to travel out of state, or because the delay created by the law will push them past the point at which they can legally obtain an abortion.

45. I find the prospect of turning patients away to be both deeply upsetting and at odds with my professional obligation to act in their best interests. Women desire screening tests for chromosomal anomalies, genetic disorders, and anatomic abnormalities so they can make the most informed decisions about expanding their families. The ability to provide a genetic diagnosis but not provide comprehensive counseling and care, which includes pregnancy continuation and termination, disrupts my ability to practice evidence-based, individualized and compassionate medicine.

46. Moreover, H.B. 214 violates a fundamental principle of medical ethics, namely that of beneficence. By restricting a constitutionally-protected right to an abortion, H.B. 214 interferes with my ability to promote the welfare of my patients (beneficence), which is a central consideration in any physician-patient relationship. Forcing a woman to carry to term against her will, or to try to travel out of state for a medical procedure when my colleagues and I are fully capable of providing the safe, legal abortion she chooses, is a violation of this ethical principle.

47. My goal as an OB/GYN and as an MFM is to fully inform my patients of all relevant information affecting their pregnancies and to provide them with the best possible care. Because H.B. 214 would impose serious civil and criminal penalties on me if I provide abortion care to any woman seeking an abortion, in whole or in part, due to a test, diagnosis, or other reason indicating fetal Down syndrome, I am unable to meet this goal.

/s/ Justin Lappen
Justin Lappen, M.D., F.A.C.O.G.

Date Signed: February 15, 2018

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

PRETERM-CLEVELAND, INC., et al.,	:	**Case No. 1:18-cv-109**
Plaintiffs,	:	**Judge Susan J. Dlott**
vs.	:	
LANCE HIMES, et al.,	:	**DECLARATION OF IRIS E. HARVEY IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION**
Defendants.	:	

I, Iris E. Harvey, pursuant to 28 U.S.C. §1746, declare under penalty of perjury that the following is true and correct:

1. I am the President and Chief Executive Officer of Planned Parenthood of Greater Ohio ("PPGOH"). PPGOH is a not-for-profit organization with headquarters in Columbus.

2. PPGOH maintains nineteen health center locations in communities throughout north, east, and central Ohio. PPGOH provides a broad range of medical services to women and men in Ohio, including birth control, gynecological examinations, cervical pap smears, diagnosis and treatment of vaginal infections, vasectomies, testing and treatment for sexually transmitted infections, HIV testing, pregnancy testing, and abortions. In addition, PPGOH provides extensive health education programs for teens and young adults as well as infant mortality reduction programs.

3. My responsibilities at PPGOH involve overseeing the services and programs provided by our health centers. I am therefore familiar with the services we provide and the patients we treat. This declaration is based upon my personal knowledge and knowledge I have

acquired in the course of my duties with PPGOH. If called and sworn as a witness, I could and would testify competently thereto. I have read the complaint in this action and verify that all of the facts regarding PPGOH are true based either on my personal knowledge or my personal investigation of those facts.

4. PPGOH provides surgical abortion up to 19 weeks 6 days gestation as measured from the first day of the woman's last menstrual period ("LMP"), and medication abortion up to 70 days LMP.

5. PPGOH's patients seek abortion for a variety of reasons, including familial, medical, financial, and personal. Among other reasons, some women have abortions because they do not want to start or add to their family at that time, some to preserve their life or their health, and some because they have become pregnant as a result of rape. Some women who seek abortions do so because the fetus has been diagnosed with a medical condition or anomaly, including Down syndrome.

6. It is at the core of PPGOH's mission to provide compassionate, non-judgmental care to our patients. This includes supporting a woman's right to make her own decision about whether or not to continue a pregnancy based on what she decides is best for herself and her family.

7. All PPGOH patients who seek an abortion have two appointments at one of our health centers, the first for the informed consent process, including a non-directive discussion regarding their options, and the second for the abortion. Part of the discussion includes ensuring that a patient is certain in her decision to terminate the pregnancy, and that her decision is informed and voluntary. If a patient is uncertain, we will not proceed with the abortion.

8. PPGOH does not require patients to disclose their reasons for seeking an abortion, nor do we believe it would be appropriate to require them do so. However, some, but not all, patients do disclose their reasons during discussions with our staff, and this includes patients who are seeking an abortion in whole or in part because of a diagnosis or indication that the fetus has Down syndrome.

9. Patients who are seeking an abortion because of a fetal anomaly, including Down syndrome, sometimes bring their medical records with them to their appointment, and these records contain information about the fetal diagnosis. We also at times request medical records for these patients from their regular obstetrician-gynecologist or maternal fetal medicine ("MFM") physician.

10. Another way we sometimes learn that a patient is seeking an abortion at PPGOH because of a fetal diagnosis of Down syndrome is through physicians, including MFM specialists, who refer patients to PPGOH. At times, these physicians will contact PPGOH or our physicians to let us know that they are referring a patient, and at that time will alert us to the fetal diagnosis of Down syndrome and often fax us a patient's medical records.

11. Patients who seek an abortion because of a fetal diagnosis of Down syndrome make up a small number of PPGOH's patients. However, PPGOH treats these patients on a regular basis, and I am certain that these patients will continue to seek care from us in the future.

12. If H.B. 214 takes effect, PPGOH will have no choice but to stop providing abortions to patients who we know are seeking an abortion in whole or in part because of a diagnosis or indication of Down syndrome in order to avoid criminal and civil penalties against PPGOH and our physicians. We will have no choice but to refer patients to an out-of-state health center.

Dated: February 15, 2018

/s/ Iris E. Harvey
Iris E. Harvey

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

PRETERM-CLEVELAND, INC., et al.,	:	**Case No. 1:18-cv-109**
Plaintiffs,	:	**Judge; Susan J. Dlott**
vs.	:	
LANCE HIMES, et al.,	:	**DECLARATION OF CHRISSE FRANCE IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION**
Defendants.	:	

I, Chrisse France, pursuant to 28 U.S.C. §1746, declare under penalty of perjury that the following is true and correct:

1. I have read the complaint in this action and verify that all of the facts regarding Preterm are true based either on my personal knowledge or my personal investigation of those facts.

2. I am the Executive Director of Preterm-Cleveland ("Preterm"), which is a plaintiff in this case. I have held this position since 1999.

3. Preterm, a nonprofit corporation organized under the laws of the State of Ohio, has operated a health care clinic in Cleveland, Ohio since 1974. Preterm provides a range of reproductive health services, including family planning services; pregnancy testing; testing and treatment for sexually transmitted diseases; and medical and surgical abortion services. Preterm provides surgical abortions through 21 weeks, 6 days of pregnancy as dated from the first day of the woman's last menstrual period ("LMP"), and medication abortions through 70 days LMP.

4. As Executive Director, I am ultimately responsible for Preterm's administrative, financial, and clinical operations. Preterm's Chief Financial Officer, Director of Counseling, Director of Clinical Services, Director of Development and Communications, Facilities Coordinator, and Administrative Assistant all report directly to me. Part of my job as Executive Director includes working with my staff and legal counsel to assess the impact of new legislation on Preterm's ability to continue to provide compassionate and high-quality services to our patients. I am familiar with the services we provide and the patients we treat. This declaration is based upon my personal knowledge and knowledge I have acquired in the course of my duties with Preterm. If called and sworn as a witness, I could and would testify competently thereto.

5. In my experience, women decide to have an abortion for many different reasons—usually more than one at a time. For example, some women have abortions because they conclude (based on any number of factors) that it is not the right time in their lives to have a child or to add to their family, or because they do not want to parent at all. Some patients seek abortions after becoming pregnant as a result of rape, or when an underlying medical condition makes continuing a pregnancy dangerous to their health or life. And some patients seek abortions after receiving a fetal diagnosis.

6. Preterm strongly supports a woman's right to make the best decision for her and her family. Our mission is to "advance reproductive health and justice by providing safe, respectful and accessible abortion and sexual health care." In advancing this mission, we work to create a nonjudgmental environment. Our website informs visitors: "We support your choices. We respect your privacy. We're committed to your safety. We trust our patients. Our patients trust Preterm."

7. As part of my role as Executive Director, I am familiar with our clinical protocols and patient counseling procedures. When a patient first calls the clinic seeking an abortion, she is asked several specific questions about her medical history. She is also informed that she must make two appointments—the first for education and informed consent, and the second for the procedure.

8. Women who are seeking abortion due to a fetal diagnosis usually mention this during their initial phone contact. Preterm offers a special program for these women, who are often struggling with difficult emotions around terminating a wanted pregnancy. We advertise this program on our website, and it is known to some of the physicians who refer patients to us. Participation in this program is indicated with a special sheet in the woman's chart.

9. At a patient's first visit to the clinic, she will meet with one of our trained patient advocates for a patient education session. Preterm engages in a non-directive discussion with all women, which means that the patient's wishes and concerns should guide the process and she should not be pushed toward any particular option. This discussion will usually begin by asking the woman an open-ended question like, "What brought you here today?" and asking whether she has considered her other options, such as continuing the pregnancy to term and parenting or placing the child for adoption. Our goal is not to judge the woman's reasons, but to create a safe environment for her to ask questions and to talk about her decision, to the extent she wants to. The purpose of the session is also for us to ensure that her decision is voluntary and informed. If the discussion reveals that a woman is uncertain about her decision, or that she is being coerced or at risk of being coerced, Preterm will not proceed with the abortion.

10. Often, but not always, a patient will disclose her reasons for the abortion during the patient education session. This includes patients who are seeking abortion due to a Down

syndrome diagnosis, as well as other fetal anomaly diagnoses. Ultimately, our goal to provide every woman with any help she might need to reach a decision about her pregnancy and to honor her decision once it is made, recognizing that the woman herself is best able to judge what is right for her and her family. For some women, the right decision will be to parent a child with Down syndrome; for others, it will be making an adoption plan; and for others, the right decision will be terminating the pregnancy.

11. Even though it is a small minority of the patients we see, based on past experience, I am certain that some women will continue to seek abortions at Preterm because of a diagnosis, screening test, and/or some other reason to believe there is fetal Down syndrome.

12. If H.B. 214 takes effect, in order to avoid criminal penalties, civil suits, and disciplinary sanctions against Preterm, as well as against its physicians, Preterm will cease providing abortions to these patients. We will have no choice but to turn them away and refer them out of state. Given that the majority of our patients are low-income, I am very concerned that some of these patients will not be able to afford a multiple-day trip out-of-state to get the abortion, and that some may go to extreme measures to raise the money they need, endangering themselves and their families. I fear that, in their desperation, others may resort to unsafe providers or methods of ending their pregnancy.

/s/ Chrisse France
Chrisse France

Date Signed: February 15, 2018

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

PRETERM-CLEVELAND, INC., et al.,	:	**Case No. 1:18-cv-109**
Plaintiffs,	:	**Judge Susan J. Dlott**
vs.	:	
LANCE HIMES, et al.,	:	**DECLARATION OF ROSLYN KADE, M.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION**
Defendants.	:	

I, Roslyn Kade, pursuant to 28 U.S.C. § 1746, declare under penalty of perjury that the following is true and correct:

1. I am a physician and plaintiff in this case and submit this declaration in support of Plaintiffs' Motion for a Temporary Restraining Order and/or Preliminary Injunction against H.B. 214.

2. I received my medical degree from the University of Cincinnati College of Medicine in 1985 and completed 2 years of residency in obstetrics and gynecology at the University Hospital in Cincinnati in 1987. I have provided family planning and outpatient gynecological services, including abortions, in Ohio for over three decades.

3. I am currently the Medical Director of Plaintiff Planned Parenthood of Southwest Ohio (PPSWO). As part of my role as Medical Director, I oversee the clinical practice and ensure that the medical services we provide comply with the standard of care and Planned

Parenthood and National Abortion Federation policies and protocols for clinical care. In addition to serving as Medical Director, I occasionally provide abortions at the clinic operated by PPSWO in the Elizabeth Campbell Medical Center, in Cincinnati. I also provide abortions at Women's Medical Center in Dayton (WMCD), which is owned and operated by Plaintiff Women's Medical Group Professional Corporation (WMGPC). I am therefore familiar with the services and with the patients at both PPSWO and WMCD. This declaration is based upon my personal knowledge and knowledge I have acquired in the course of my duties with both clinics. If called and sworn as a witness, I could and would testify competently thereto.

4. I have read the complaint in this action and verify that all of the facts regarding PPSWO, WMGPC, WMCD and me are true based either on my personal knowledge or my personal investigation of those facts.

5. PPSWO is a non-profit corporation organized under the laws of the State of Ohio. It and its predecessor organizations have provided care in Ohio since 1929. PPSWO provides a broad range of medical services to women and men at seven health centers in Southwest Ohio, including: birth control, annual gynecological examinations, cervical pap smears, diagnosis and treatment of vaginal infections, testing and treatment for certain sexually transmitted diseases, HIV testing, pregnancy testing, and abortions. PPSWO provides surgical abortions through 21 weeks 6 days of pregnancy LMP and medication abortions through 70 days LMP.

6. WMGPC and its predecessors have been providing abortions for women in the Dayton area since 1975. WMCD provides surgical and medication abortions, pregnancy testing, and birth control health care services to women. WMCD provides previability surgical abortions no later than 21 weeks 6 days of pregnancy LMP and medication abortions through 70 days LMP.

7. When a woman calls either PPSWO or WMCD, the clinic first requires her to visit the clinic at least twenty-four hours in advance of her scheduled procedure to complete the informed consent process with a physician and participate in a non-directive discussion with clinic staff regarding her options (carrying the pregnancy to term and parenting or placing the child for adoption, or abortion). During that first visit, she also has blood drawn and receives an ultrasound, during which she is offered the ability to see or hear the fetal heartbeat and ultrasound image. She will then return for a second visit at least twenty-four hours later, during which the abortion will be performed.

8. I am aware that some of our patients seek abortions after receiving a fetal diagnosis, including Down syndrome. These patients come to PPSWO and WMCD from across Ohio, and from out-of-state, as well. Although we do not require patients at PPSWO or WMCD to tell us the reason or reasons they are seeking an abortion, patients who are seeking an abortion after a fetal diagnosis usually disclose this fact when they call to make an appointment or during the pre-abortion informed consent and nondirective options discussion. Sometimes these patients or their physicians forward their medical records to us, as well.

9. In my experience, patients who decide to have an abortion because of a fetal diagnosis have already undergone extensive counseling with genetic counselors and/or maternal-fetal medicine physicians, as well as engaged in extensive reflection and conversation with their partners and families, before coming to us for care.

10. If H.B. 214 is allowed to take effect, in order to avoid criminal penalties, civil suits, and disciplinary sanctions, I will stop performing abortions, as will the other physicians at PPSWO and WMCD when we know, or think there is a high probability, that the woman is

seeking the abortion due to a test result indicating Down syndrome, a prenatal diagnosis of Down syndrome, or any other reason to believe that the fetus has Down syndrome.

11. If we are forced to turn these patients away, they will have no choice but to seek care out-of-state. For some of our patients, raising the necessary funds for the additional travel and accommodations, on top of the cost of the procedure, will cause extreme hardship. For others, it will simply be impossible; these women will be forced to carry their pregnancies to term against their will. Even for those women who are ultimately able to obtain the care they need, they will likely experience unnecessary delay making the arrangements and coming up with the funds, which can increase both the risks and costs related to the abortion procedure. This will be devastating to the women and families who come to us in their hour of need, and devastating to the physicians and staff at PPSWO and WMCD, including myself, who are dedicated to providing compassionate and nonjudgmental health care to our patients.

/s/Roslyn Kade
Roslyn Kade

Date Signed: 2/14/18

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

PRETERM-CLEVELAND, INC., et al.,	:	**Case No. 1:18-cv-109**
Plaintiffs,	:	
vs.	:	**Judge: Susan J. Dlott**
	:	
LANCE HIMES, et al.,	:	**PROPOSED TEMPORARY**
	:	**RESTRAINING ORDER**
Defendants.	:	
	:	

Upon consideration of the Plaintiffs' motion for a temporary restraining order and/or preliminary injunction and the response of Defendants to Plaintiffs' motion for a temporary restraining order and/or preliminary injunction, this Court has found and concluded, for the specific reasons required under Federal Rule of Civil Procedure 65(d), that Plaintiffs have shown (1) a likelihood of success on the merits of their claim, (2) that they will suffer irreparable harm if an injunction is not issued, and (3) that the balance of harm and the public interest weigh in favor of granting the temporary restraining order and preliminary injunction. Specifically, Plaintiffs have shown a likelihood of success on their claim that Ohio House Bill 214 of the 132nd General Assembly ("H.B. 214") is an unconstitutional deprivation of Plaintiffs' Fourteenth Amendment right to substantive due process because it bans previability abortions based on one reason for seeking them.

THEREFORE, it is hereby ORDERED that the motion is GRANTED and Defendants; their officers, agents, servants, employees, and attorneys; and those persons in active concert or participation with them who receive actual notice of this Order, are TEMPORARILY RESTRAINED from enforcing H.B. 214 until _____, _____, 2018.

Plaintiff shall not be required to post bond. *Moltan Co. v. Eagle-Picher Indus., Inc.*, 55 F.3d 1171, 1176 (6th Cir. 1995).

IT IS SO ORDERED.

Date: _____

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DISTRICT COURT JUDGE