IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

PRETERM-CLEVELAND, *et al.,* *Plaintiffs,* v. DAVE YOST, *et al.*, *Defendants.*	Case No. Judge

PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

Pursuant to Civ.R. 65, Plaintiffs Preterm-Cleveland; Planned Parenthood Southwest Ohio Region; Catherine Romanos, M.D.; Planned Parenthood Greater Ohio; Women's Med Group Professional Corporation; and Northeast Ohio Women's Center, LLC (collectively, "Plaintiffs") hereby move this Court for a preliminary injunction to enjoin enforcement of R.C. 2317.56, 2919.192, 2919.193, and 2919.194 (collectively, the "Challenged Requirements").

Last year, Ohioans enshrined a robust affirmative right to reproductive freedom in the Ohio Constitution. Article I, Section 22 of the Ohio Constitution now protects every Ohioan's "right to make and carry out [their] own reproductive decisions, including but not limited to decisions on [] abortion." Ohio Constitution, Article I, Section 22(A). Under the Amendment's rigorous standard, the State is constitutionally forbidden from directly or indirectly burdening, penalizing, prohibiting, interfering with, or discriminating against either (1) an individual's voluntary exercise of this right or (2) a person or entity that assists an individual exercising this right, *unless* the State can satisfy the extremely heavy burden of showing that it is using the least restrictive means to advance the individual's health in accordance with widely accepted and evidence-based standards of care. Ohio Constitution, Article I, Section 22(B).

As supported by the accompanying Memorandum, and the affidavits and exhibits attached

thereto, Plaintiffs have more than a substantial likelihood of success on the merits of their claim that the Challenged Requirements violate their patients' constitutional rights under Article I, Section 22, of the Ohio Constitution and preliminary injunctive relief is necessary and appropriate to stop the ongoing and irreparable harms that the Challenged Requirements are currently inflicting on Plaintiffs and their patients, for which there is no adequate remedy at law.

Together, the Challenged Requirements force abortion patients to (1) delay obtaining time-sensitive abortion care for least 24 hours, and often longer, at risk to their health, well-being, and privacy; (2) make an unnecessary, in-person visit to a clinic which—for the vast majority of patients—necessitates jumping through the logistical and financial hoops associated with attending at least two in-person appointments and further delays their care, amplifying associated risks; and (3) receive state-mandated information that is at best irrelevant and at worst distressing, stigmatizing and misleading, all without medical purpose or countervailing benefit to patient health. In so doing, the Challenged Requirements burden, penalize, interfere with, and discriminate against Ohioans in exercising their right to abortion and Plaintiffs in assisting them; and, in some cases, the Challenged Requirements even prevent Ohioans from obtaining an abortion entirely. At the same time, the Challenged Requirements do nothing to advance Ohioans' health, let alone through the least restrictive means. As such, the Challenged Requirements are in stark violation of Article I, Section 22 of the Ohio Constitution.

The Challenged Requirements are having devastating consequences on the health, well-being, and dignity of Ohioans seeking fundamental abortion care, and on Plaintiffs as abortion providers, who desire only to act in accordance with the standard of care and medical ethics in providing their patients with compassionate, timely abortion care. A preliminary injunction is necessary to stop these ongoing and irreparable constitutional, medical, emotional, psychological, dignitary, and other harms. An injunction will not harm any third parties and will serve the public interest by preventing

the ongoing violation of Plaintiffs' patients' constitutional rights.

Accordingly, Plaintiffs respectfully request that this Court enjoin Defendants, as well as their agents, employees, servants, and successors, and any persons in active concert or participation with them, from enforcing the Challenged Requirements, and/or any other Ohio statute or regulation that could be understood to give effect to these provisions, during the pendency of this litigation, as well as from taking any later enforcement action premised on conduct that occurred while such relief was effect.

Respectfully submitted,

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**Motions for pro hac vice forthcoming*

IN THE COURT OF COMMON PLEAS
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PRETERM-CLEVELAND, *et al.*, *Plaintiffs*, v. DAVE YOST, *et al.*, *Defendants.*	Case No. Judge **PLAINTIFFS' MEMORANDUM IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION**

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I. INTRODUCTION

In November 2023, Ohio voters enshrined a robust right to abortion in Article I, Section 22 of the State Constitution, as the Right to Reproductive Freedom with Protections for Health and Safety (the "Amendment"). The Amendment protects the right to "make and carry out one's own reproductive decisions," including whether to have an abortion, and instructs that the State "shall not, directly or indirectly[] burden, penalize, prohibit, interfere with, or discriminate against either: [a]n individual's voluntary exercise of this right or [a] person or entity that assists an individual exercising this right." Ohio Constitution, Article I, Section 22(A)–(B). In adopting the Amendment by an overwhelming margin, Ohioans sent a clear message to the State: Stay out of our private reproductive decisions.

Plaintiffs bring this challenge to vindicate the Amendment's mandate with respect to Ohio's waiting period, in-person visit, and state-mandated information requirements for abortion (together, the "Challenged Requirements" or the "Requirements"). *See* R.C. 2317.56, 2919.192, 2919.193, and 2919.194. The Challenged Requirements force patients seeking abortion in Ohio to make a separate in-person trip to an abortion provider to receive irrelevant, stigmatizing, and sometimes misleading information, and then to delay their abortion care for at least 24 hours (and in practice often far longer). Providers face steep criminal, civil, and professional penalties if they fail to comply with these medically unnecessary and harmful requirements. The Challenged Requirements blatantly violate the Amendment by burdening, penalizing, interfering with, and discriminating against both an individual's right to make and carry out their decision to have an abortion and providers' ability to assist them in doing so, and by prohibiting Ohioans from obtaining abortion altogether in certain cases.

The Challenged Requirements harm individuals seeking abortion care in Ohio and their healthcare providers each day they remain in effect. Patients seeking abortion in Ohio are forced

to endure financial, logistical, and emotional burdens in accessing care and to suffer irreparable physical, economic, emotional, and psychological harms. At the same time, abortion providers like Plaintiffs are forced to disregard their own medical judgment and their ethical duties to respect their patients' autonomy and act in their patients' best interests under threat of serious sanctions. Accordingly, Plaintiffs respectfully move this Court to intervene to enjoin these ongoing constitutional violations and serious, irreparable harm by issuing a preliminary injunction preventing Defendants from continuing to enforce the Challenged Requirements during the pendency of this litigation.

II. FACTUAL BACKGROUND

A. Abortion Care in Ohio

There are two types of abortion available in Ohio: medication abortion and procedural abortion. Liner Aff. ¶¶ 10–11. The most common form of medication abortion uses a two-drug regimen to terminate a pregnancy. Romanos Aff. ¶ 17. Patients take the first medication, mifepristone, which stops the pregnancy from developing, and then a second medication, misoprostol, approximately 24–48 hours later, which causes the uterus to cramp and thereby empties its contents in a process similar to a miscarriage. *Id.* Although medication abortion is a safe and effective way to terminate a pregnancy through at least 11 weeks, as dated from the first day of a patient's last menstrual period ("LMP"), Ohio law prohibits it after 10 weeks LMP. R.C. 2919.123; Liner Aff. ¶ 11; Romanos Aff. ¶ 17. Some people prefer medication abortion to procedural abortion because it feels more natural, it can be done privately at home when the patient chooses, and it does not involve inserting instruments into the body—which may be traumatic for those who have been victims of rape or incest, among others. Burkons Aff. ¶ 33; Haskell Aff. ¶ 28; Krishen Aff. ¶ 22; Maple Aff. ¶ 34. In addition, procedural abortion may be medically

contraindicated for some patients, making medication abortion the safer method. Burkons Aff. ¶ 33; Krishen Aff. ¶ 22.

Procedural abortion involves using aspiration (i.e., gentle suction) and/or instruments to empty the uterus. Romanos Aff. ¶ 18. In Ohio, procedural abortion is available through 21 weeks, 6 days LMP. Haskell Aff. ¶ 8; Liner Aff. ¶ 11; Maple Aff. ¶ 5; *see* R.C. 2919.201 (banning abortion after 20 weeks "probable postfertilization age," or 22 weeks LMP).

The reasons for seeking abortion care are varied. On average, patients express as many as five individual reasons impacting their decision to seek an abortion. Romanos Aff. ¶ 15. The decision to have an abortion, continue a pregnancy, or parent a child is informed by individual values, beliefs, culture, religion, family circumstances, economic circumstances, resource access, reproductive history, and physical and mental health considerations. Liner Aff. ¶ 12; Romanos Aff. ¶ 15. Some patients seek an abortion because they determine it is not the right time to add a child to their family, perhaps due to caring for children they already have. Liner Aff. ¶ 12; Romanos Aff. ¶ 15. Indeed, the majority of Plaintiffs' abortion patients are already parents, and, for some, continuing a pregnancy and having an additional child can place economic and emotional strains on a family that are simply not manageable. Liner Aff. ¶ 12. This is especially so for people with very limited financial resources, who comprise the majority of both patients trying to access abortion care nationwide and Plaintiffs' patient population in Ohio. Burkons Aff. ¶ 9; Haskell Aff. ¶ 9; Maple Aff. ¶ 6; Romanos Aff. ¶ 6. Others have an abusive partner and fear they will be tethered to them if they have a child together; still others have become pregnant as a result of rape or incest. Burkons Aff. ¶ 10; Haskell Aff. ¶ 9; Romanos Aff. ¶ 11. Others decide to have an abortion to pursue education or career goals. Burkons Aff. ¶ 10; Liner Aff. ¶ 12; Romanos Aff. ¶ 15.

Abortion is extremely common in the United States: Approximately one in four women in this country will have had an abortion by age 45. Romanos Aff. ¶ 14. Abortion is also among the safest medical interventions. Complications from both medication and procedural abortion are extremely rare. Romanos Aff. ¶ 19. In the rare cases when complications occur, they are usually managed safely and effectively in an outpatient clinic setting, either at the time of the abortion or at a follow-up visit. *Id.*

Abortion is also far safer than carrying a pregnancy to term and giving birth. *Id.* Even for patients with uncomplicated pregnancies, pregnancy poses significant health risks and extraordinary physical challenges. Romanos Aff. ¶ 60. It places significant stress on most major organs and results in profound and long-lasting physiological changes. Haskell Aff. ¶ 27.

Pregnancy complications are also extremely common. Romanos Aff. ¶ 61. Some of the more common complications include preeclampsia, pulmonary hypertension, and maternal cardiac disease. *Id.* All of these conditions can result in serious, permanent harm to an individual's health. *Id.* Pregnancy may also exacerbate existing health conditions or cause new ones, such as diabetes, hypertension, heart disease, autoimmune disorders, or mental health concerns, and people with such conditions face even greater risk of pregnancy complications. *Id.*

In addition, pregnancy carries with it a much higher risk of death than abortion: the risk of maternal death associated with childbirth is approximately 12 to 14 times higher than that associated with legal abortion in the United States. Burkons Aff. ¶ 13; Romanos Aff. ¶ 19. Maternal mortality risk is an even graver concern for patients already facing institutional racism in accessing medical care. In part because pregnancy complications disproportionately affect Black women, the maternal mortality rate is significantly higher for Black women throughout the

country and in Ohio, where they are two and a half times more likely than white women to die from a pregnancy-related cause. Romanos Aff. ¶ 65.

Finally, while abortion at any point in pregnancy is extremely safe, and always far safer than carrying a pregnancy to term and giving birth, delays in accessing abortion care increase the risk to patient health, both due to remaining pregnant longer, and because the risks associated with abortion increase as pregnancy progresses. Burkons Aff. ¶ 32; Haskell Aff. ¶ 28; Krishen Aff. ¶ 21; Liner Aff. ¶ 33; Romanos Aff. ¶ 56.

B. The Challenged Requirements

1. Ohio Revised Code 2317.56

R.C. 2317.56 mandates that physicians meet with patients seeking abortion in person at least 24 hours prior to an abortion being performed or induced to provide certain state-mandated information, as well as copies of state-produced materials about fetal development, family planning information, and publicly-funded support options. R.C. 2317.56(B)(1), (B)(2)(b).[1] Before a patient can receive abortion care, the patient must certify in writing that they have received all of the required information and materials. R.C. 2317.56(B)(4).[2] The only exception to the requirements of R.C. 2317.56 is for cases of medical emergency or medical necessity, narrowly

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[1] The State-produced materials may be found online here: https://odh.ohio.gov/wps/wcm/connect/gov/c9575676-b521-4fdc-a537-6db2f3f59335/fetaldevelopmentenglish2011.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-c9575676-b521-4fdc-a537-6db2f3f59335-mi7QSSX (accessed Mar. 28, 2024).

[2] For procedural abortions, R.C. 2317.56(B)(4)(c)–(d) requires the patient to sign and certify additional forms addressing options for, and elections regarding, disposition of the uterine contents after the procedure. *See also* R.C. 3726.03 and 3726.14. However, these provisions are currently enjoined by the court's preliminary injunction order in *Planned Parenthood Sw. Ohio Region v. Ohio Dept. Health*, Entry Granting Pls.' Second Mot. for Prelim. Inj., Hamilton C.P. No. A 2100870 (Jan. 31, 2022). Because these provisions are the subject of a separate lawsuit, they are not at issue in this case.

defined as applying only if an "immediate" abortion is necessary due to a pregnancy complication. R.C. 2317.56(A)(1)–(2), 2317.56(B), and 2919.16(F).[3] In all other circumstances—including rape, incest, a fatal fetal diagnosis, or intimate partner violence—R.C. 2317.56's requirements are mandatory.

Abortion providers, such as Plaintiffs, face severe professional and civil penalties if they do not comply with R.C. 2317.56's requirements. The state medical board may limit, revoke, or suspend a physician's medical license based on a violation of R.C. 2317.56. *See* R.C. 4731.22(B)(23). In addition, a patient may bring a civil action for compensatory and exemplary damages against a provider who violates R.C. 2317.56. *See* R.C. 2317.56(G)(1).

2. Ohio Revised Code 2919.192, 2919.193, and 2919.194

R.C. 2919.192, 2919.193, and 2919.194 compel testing for fetal or embryonic cardiac activity prior to an abortion, and—if such activity is detected—require that the patient receive additional state-mandated information, followed by at least 24 hours' delay. R.C. 2919.192 and 2317.56(B)(2)(c)–(B)(3). Specifically, if embryonic or fetal cardiac activity is detected, then at least 24 hours before providing an abortion, the physician must (1) give the patient written confirmation that cardiac activity is present; (2) tell the patient the statistical probability of bringing the embryo or fetus to term based on gestational age; and (3) have the patient sign a form acknowledging receipt of this information. R.C. 2919.194(A)(1)–(3). The physician must also

[3] "Medical emergency" is defined to as "a condition that in the physician's good faith medical judgment, based upon the facts known to the physician at that time, so complicates the woman's pregnancy as to necessitate the immediate performance or inducement of an abortion in order to prevent the death of the pregnant woman or to avoid a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman that delay in the performance or inducement of the abortion would create." R.C. 2317.56(A)(1) and 2919.16(F). "Medical necessity" is defined as "a medical condition of a pregnant woman that, in the reasonable judgment of the physician who is attending the woman, so complicates the pregnancy that it necessitates the immediate performance or inducement of an abortion." R.C. 2317.56(A)(2).

record the estimated gestational age of the embryo or fetus, the method used to test for cardiac activity, the date and time of the test, and its results in the patient's medical record. R.C. 2919.192(A). These statutory requirements may be waived only in cases of documented medical emergency; in all other circumstances, the requirements of R.C. 2919.192, 2919.193, and 2919.194 are mandatory. R.C. 2919.193(B).

Failure to test for fetal or embryonic cardiac activity prior to providing an abortion as required by R.C. 2919.192 is a fifth-degree felony. R.C. 2919.193, 2929.14(A)(5), and 2929.18(A)(3)(e). Failure to provide the state-mandated information and obtain the written acknowledgment at least 24 hours before an abortion when fetal or embryonic cardiac activity is detected, as required by R.C. 2919.194, is a first-degree misdemeanor on the first offense and a fourth-degree felony on each subsequent offense. R.C. 2919.194(E), 2929.24(A)(1), 2929.28(A)(2)(a)(i), 2929.14(A)(4), and 2929.18(A)(3)(d).

In addition to these criminal penalties, providers face severe professional and civil penalties. The state medical board may assess a forfeiture of up to $20,000 for each violation of R.C. 2919.192, 2919.193, or 2919.194. *See* R.C. 2919.1912(A). The state medical board may also limit, revoke, or suspend a physician's medical license for failing to test for embryonic or fetal cardiac activity prior to providing an abortion or for failing to comply with the documentation requirements. R.C. 2919.193(A)(2) and 4731.22(B)(46). In addition, a patient may bring a civil action for compensatory and exemplary damages against a provider who fails to test for embryonic or fetal cardiac activity prior to providing an abortion. R.C. 2919.193(A)(1).

C. Informed Consent Practices

1. Informed Consent in General and in Ohio

Informed consent is a cornerstone of the practice of medicine and is deeply ingrained in the education and training of health care professionals. Haskell Aff. ¶ 13; Krishen Aff. ¶ 7;

Romanos Aff. ¶ 20. Informed consent is a process by which a health care provider educates the patient about the nature and purpose of a proposed procedure or treatment, as well as its risks, benefits, and alternatives. Burkons Aff. ¶ 14; Liner Aff. ¶ 17; Romanos Aff. ¶ 21. The patient must also have an opportunity to have any questions answered in order to make a fully informed and voluntary decision as to whether to proceed with the procedure or treatment. Burkons Aff. ¶¶ 14–15; Liner ¶ 17; Romanos Aff. ¶ 27.[4]

This is not only the standard of care, but also a fundamental component of ethical medical practice, which requires respect for a patient's self-determination and bodily autonomy. Burkons Aff. ¶ 20; Krishen Aff. ¶ 7; Romanos Aff. ¶¶ 21–22. In this vein, it is also a basic tenet of ethical medical practice that informed consent should be tailored to the specific needs, concerns, and values of each patient, and the provider's communication with the patient should account for the complexity of the medical information and any other factors within the provider's awareness that would impact a patient's decision. Haskell Aff. ¶ 30; Krishen Aff. ¶¶ 7, 8; Romanos Aff. ¶ 24. Indeed, both the American Medical Association ("AMA")—the largest national association of state and specialty medical societies dedicated to promoting medicine and the betterment of public health—and the American College of Obstetricians and Gynecologists ("ACOG")—the preeminent professional association of obstetricians and gynecologists—have affirmed that each

[4] R.C. 2317.54, which lays out evidentiary presumptions regarding written informed consent for medical treatment, reinforces this universal understanding of informed consent. Specifically, R.C. 2317.54 instructs that written consent to a surgical or medical procedure "shall be presumed valid and effective" if it sets forth in general terms the nature and purpose of the procedure or procedures; what the procedures are expected to accomplish, together with the reasonably known risks; and "sets forth the names of the physicians who shall perform the intended surgical procedures," as long as the patient also acknowledges that this information has been provided and their questions have been answered. *See also Wheeler v. Wise*, 133 Ohio App.3d 564, 572, 729 N.E.2d 413 (10th Dist.1999).

patient's desire to receive or decline particular information should be considered in the consent process. Romanos Aff. ¶ 25.

Ohio law does not require a separate in-person visit for informed consent for any other medical procedure or treatment. Nor does Ohio law impose a mandatory waiting period for any similarly time-sensitive medical procedure or treatment. Burkons Aff. ¶ 24; Haskell Aff. ¶ 20; Liner Aff. ¶ 24; Romanos Aff. ¶ 37. Rather, it is standard for informed consent to be sought and provided shortly before a medical procedure or treatment. Burkons Aff. ¶ 24; Romanos Aff. ¶ 22. This is true for other medical treatments and procedures related to pregnancy, including miscarriage management and procedures that carry a risk of miscarriage, Romanos Aff. ¶ 22, as well as major surgeries like tubal ligations and cesarean sections, *id.*; Burkons Aff. ¶ 24.

2. Plaintiffs' Informed Consent Practices

Because it is required by both medical ethics and general Ohio law governing informed consent, Plaintiffs always ensure that their patients have made a fully informed and voluntary decision to consent to an abortion before proceeding to provide care. Burkons Aff. ¶¶ 17, 19, 40; Romanos Aff. ¶ 27; Haskell Aff. ¶ 14; Liner Aff. ¶ 21. This would not change if the Challenged Requirements were enjoined. Indeed, Plaintiffs' consent practices, which are tailored to the individual patient, are more robust than those mandated by the Challenged Requirements, and better reflect best medical practice. *See, e.g.*, Romanos Aff. ¶ 25.

To start, Plaintiffs ensure that every patient is informed of the nature and purpose of abortion, its risks, benefits, and alternatives, and has an opportunity to ask any questions. Burkons Aff. ¶¶ 14–15; Haskell Aff. ¶ 15; Krishen Aff. ¶ 7; Liner Aff. ¶ 17; Maple Aff. ¶ 20; Romanos Aff. ¶ 32. Because patients' unique medical history and circumstances may impact abortion risks and benefits, Plaintiffs tailor this discussion to each patient. Krishen Aff. ¶ 8; Liner Aff. ¶ 24; Romanos Aff. ¶¶ 25, 26. For example, procedural abortion may pose greater risks than medication

abortion for certain patients, based on their anatomy and prior medical history. Romanos Aff. ¶ 24. Likewise, a patient's particular living situation—such as homelessness or living with an abusive partner—may figure into the risks and benefits of a particular kind of abortion. *Id.* In each case, Plaintiffs seek to meet each patient where they are, providing full and comprehensive information in terms that are accessible to that patient. Krishen Aff. ¶ 8; Liner Aff. ¶ 24; Romanos Aff. ¶ 24.

Plaintiffs provide multiple opportunities for private discussions with staff and health care providers who ensure that all patient questions are answered, their concerns are addressed, and that they feel fully informed and confident in their decisions. Burkons Aff. ¶¶ 18, 21; Romanos Aff. ¶ 30, Maple Aff. ¶¶ 12–18; Haskell Aff. ¶ 16; Krishen ¶ 9; Liner ¶ 22. For example, at the Women's Med Center Dayton ("WMCD"), patients have private, one-on-one interactions with at least two or three separate staff members prior to meeting with the physician, during which they are able to ask questions and share any concerns. Haskell Aff. ¶ 15; *see also* Maple Aff. ¶ 13 (describing Preterm-Cleveland ("Preterm's") patient education process).

While the overwhelming majority of Plaintiffs' patients arrive at the clinic already firm in their decision to end their pregnancy, Plaintiffs' staff are trained to notice signs of patient hesitancy, uncertainty, or coercion. Burkons Aff. ¶ 17; Haskell Aff. ¶ 17; Krishen Aff. ¶¶ 9–10; Liner Aff. ¶¶ 20, 22; Maple Aff. ¶¶ 16, 17, 19. In rare situations in which Plaintiffs or their staff sense hesitancy, they check in with the patient, ensure that the patient is provided with any additional information or resources they might want or need, including further counseling about all of their other options (i.e., carrying to term, parenting, and adoption), and—if they suspect coercion—investigate this concern privately with the patient. Burkons Aff. ¶¶ 17, 19; Maple Aff. ¶¶ 12, 14, 16; Romanos Aff. ¶¶ 27, 31, 34–36; Haskell Aff. ¶ 17; Liner Aff. ¶ 20. Plaintiffs will not proceed with an abortion unless the patient is sure of their decision, and they are comfortable

that the patient's decision is fully informed and voluntary. Burkons Aff. ¶ 18; Maple Aff. ¶¶ 15–17, 20; Romanos Aff. ¶¶ 34–35; Haskell ¶¶ 15–17.

D. Impact of the Challenged Requirements

The Challenged Requirements can be boiled down to three interrelated mandates that: (1) certain state-mandated information be provided to all abortion patients, regardless of their individual circumstances (the "State Information Requirement"); (2) all patients make a separate trip to the clinic order to receive that information in person (the "In-Person Requirement"); and (3) after receiving that information, patients delay time-sensitive medical care for at least 24 hours, and in practice usually much longer (the "Waiting Period Requirement"). As detailed below, far from advancing Ohioans' health, these requirements individually and collectively burden, penalize, discriminate against, interfere with, and sometimes prohibit patients' exercise of their right to abortion and providers' ability to assist them in doing so.

1. The Waiting Period Requirement

a. Impact of the Waiting Period Requirement on Patients

While, on paper, the Waiting Period Requirement imposes a 24-hour delay between a patient's receipt of state-mandated information at their first appointment and their abortion, R.C. 2317.56, in practice, patients are often forced to wait much longer—sometimes several days or even weeks—before the second appointment, depending on the patient's personal and financial circumstances, clinic availability, and the required care. Romanos Aff. ¶¶ 45, 51; Maple Aff. ¶¶ 22, 25–26; Haskell Aff. ¶ 26; Liner Aff. ¶ 36; Krishen Aff. ¶¶ 14, 16, 18, 19, 24.[5] For example, some

[5] For instance, WMCD and Preterm only provide certain procedural abortions in the morning due to the need for fasting with sedation and anesthesia and the need to monitor the patient after the procedure. Thus, if a patient presents for their first informed consent visit in the afternoon, they cannot return until at least two days later because the next available morning abortion appointment would be less than 24 hours later. Romanos Aff. ¶ 51; Maple Aff. ¶ 24. Likewise, if a clinic is not

patients have work schedules that leave them free only on Saturdays. Maple Aff. ¶ 22. Or they may be able to secure childcare only on certain days. *Id.* Many patients who are struggling financially need to take time, even up to several weeks, to gather the money necessary to make another trip back to the clinic. *Id.*; *see supra* Section II.A (stating that a majority of abortion patients are poor or low-income). Often, patients are forced to reschedule, sometimes more than once, due to problems beyond their control, such as car trouble or childcare falling through. Maple Aff. ¶ 23.

This delay imposes unnecessary physical and emotional harms on patients in conflict with medical ethics and the standard of care, which requires health care without unnecessary delay. Forcing a person to continue a pregnancy against their will risks harm to their physical, mental, and emotional health, as well as the stability and well-being of their family. Burkons Aff. ¶ 35; Haskell Aff. ¶ 28; Krishen Aff. ¶ 21; Maple Aff. ¶¶ 27–30. As noted above, while abortion is very safe, the risks associated with it increase as pregnancy progresses, as do the costs. *See, e.g.*, Maple Aff. ¶ 32; Romanos Aff. ¶ 54. Increases in cost can then result in further delay, especially for the majority of abortion patients who are poor or low-income, as patients must raise additional funds necessary to pay for more expensive care, pushing the abortion even further out. Haskell Aff. ¶ 29; Maple Aff. ¶¶ 30, 32; Romanos Aff. ¶ 54. Thus, unnecessary delays in accessing desired abortion care can increase both the medical risk and the costs of abortion for the patient, on top of the harms to patient health and well-being associated with being forced to remain pregnant (and subjected to the physiological strains and risks associated with pregnancy) for longer. Burkons Aff. ¶¶ 35–36; Romanos Aff. ¶¶ 57, 60; Haskell Aff. ¶¶ 29–30; Liner Aff. ¶¶ 38, 41.

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open every day of the week, depending on when their first appointment takes place, a patient may have to wait at least an additional day or two to return. Maple Aff. ¶ 25.

Some patients experience particularly severe harm to their health due to the Waiting Period Requirement. For example, a patient seeking an abortion so that they can begin cancer treatment may be forced to put off their procedure, thus delaying critical health care for no medical reason. Liner Aff. ¶ 32. Additionally, a significant number of patients suffer from hyperemesis gravidarum ("HG"), which is a condition in which pregnancy-induced nausea and vomiting are so severe that patients suffer weight loss and severe dehydration. Burkons Aff. ¶ 36; Liner Aff. ¶ 32; Romanos Aff. ¶ 57. HG may require hospitalization, steroids, and treatment with intravenous fluids and medication, potentially for the duration of the pregnancy. Romanos Aff. ¶ 57. Having to wait 24 hours or more forces patients with HG to remain hospitalized or endure severe and often debilitating symptoms for longer than necessary. Romanos Aff. ¶¶ 60–61; Burkons Aff. ¶ 36. As another example, if a patient is having a miscarriage, but the fetus or embryo still has cardiac activity, providers are forced to send the patient home for a minimum of 24 hours, which not only extends their grief but also creates a risk of hemorrhaging and miscarrying outside the medical setting. Romanos ¶¶ 64, 77. This could result in severe trauma and lasting harm to the patient's health. *Id.*

These delays may also force patients to forgo a chosen or medically indicated abortion method. Burkons Aff. ¶ 34; Haskell Aff. ¶ 28; Krishen Aff. ¶ 22; Liner Aff. ¶ 37; Romanos Aff. ¶ 54. For example, patients approaching the 10-week LMP cut-off for a medication abortion in Ohio may be forced instead to undergo a procedural abortion as a result of the mandatory delay. R.C. 2919.123; Burkons Aff. ¶ 34; Krishen Aff. ¶ 22; Liner Aff. ¶ 37; Romanos Aff. ¶ 54. Especially for patients who would have preferred medication abortion—for medical reasons, privacy, or due to concerns regarding re-traumatization from insertion of instruments into the body—this can be deeply upsetting. Krishen Aff. ¶ 22; Liner Aff. ¶ 37. Moreover, a patient facing

a diagnosis of a fetal condition at 20 weeks LMP, which is often when such conditions are diagnosed, may—as a result of being forced to delay care—be pushed past Ohio's legal abortion limit of 22 weeks LMP. Krishen Aff. ¶ 23; Liner Aff. ¶ 34; Maple Aff. ¶ 35; Romanos Aff. ¶ 54.

Delays in care can also exacerbate the emotional harm to patients with wanted pregnancies who have already arrived at the difficult decision to obtain an abortion. Burkons Aff. ¶ 35; Maple Aff. ¶ 30; Haskell Aff. ¶ 31; Liner Aff. ¶ 35. Patients who are terminating a pregnancy due to a fetal diagnosis have usually spent days or weeks reviewing information with other health care providers and deliberating before arriving at the decision to proceed with an abortion. Liner Aff. ¶ 34; Romanos Aff. ¶ 62. The state-mandated delay serves only to prolong and compound their grieving process. Liner Aff. ¶ 34. It also inhibits patients' ability to exercise their personal autonomy and free will and "suggest[s] an outright mistrust of patients' ability to make their own decisions and exercise their agency." Haskell Aff. ¶ 19; *see also* Liner Aff. ¶ 23; Romanos Aff. ¶ 38. Other patients, especially those whose pregnancies resulted from rape or incest, are so distressed that they do not feel they can bear being pregnant a single day or week longer. Burkons Aff. ¶ 35; Haskell Aff. ¶ 28; Liner Aff. ¶ 35; Maple Aff. ¶ 29. Finally, for patients who are experiencing intimate partner violence, the mandatory delay can force them to remain in already unsafe situations even longer and risks compromising their privacy, which could expose them to heightened risk of harm from their abuser. Romanos Aff. ¶ 66; Burkons Aff. ¶ 37; Maple Aff. ¶ 31; Liner Aff. ¶ 30; Krishen Aff. ¶ 17.

The Waiting Period Requirement likewise stigmatizes and discriminates against patients seeking abortion, as only abortion and no other form of time-sensitive reproductive health care is subjected to a mandatory delay. Burkons Aff. ¶ 24; Haskell Aff. ¶ 20; Liner Aff. ¶ 24; Romanos Aff. ¶ 37. In singling out this form of health care for differential and unfavorable treatment, the

State of Ohio is essentially telling abortion patients that it "believes that something about the care they are seeking is especially shameful or wrong." Romanos Aff. ¶ 75. This indignity is insulting to patients and shows complete disregard for their moral agency and their individual circumstances. For example, one patient who was serving in the military in Afghanistan had to take four flights home to Ohio for a first-trimester abortion, only to be told to wait an additional 24 hours before obtaining care. Romanos Aff. ¶ 50. As another example, a couple who grappled with news of a fetal diagnosis, researched options on their own, and ultimately decided to terminate the pregnancy was still required to go home and think about their decision for another 24 hours after their first appointment with the abortion provider. Romanos Aff. ¶ 49.

The harms imposed on Ohioans by the Waiting Period Requirement are particularly troubling because they lack any medical justification. Burkons Aff. ¶ 25; Krishen Aff. ¶ 11; Liner Aff. ¶¶ 23, 35; Romanos Aff. ¶ 38. In fact, a mandatory delay is contrary to the medical standard of care and contravenes the prevailing medical consensus that delaying an abortion increases risk of harm to the patient. Burkons Aff. ¶ 40; Romanos Aff. ¶¶ 60, 64, 77; *see also* Natl. Academies of Science, Eng. & Medicine, *The Safety and Quality of Abortion Care in the United States* 78 (2018), available at https://nap.nationalacademies.org/read/24950/chapter/1 (accessed Mar. 26, 2024) [hereinafter "Natl. Academies Report"] ("State regulations that require [patients] to make multiple in-person visits and wait multiple days delay the abortion" and "delaying the abortion increases the risk of harm to the [patient]."). Thus, far from advancing patient health, the Waiting Period Requirement affirmatively harms patients' health by preventing physicians from providing timely care to their patients.

b. Impact of the Waiting Period Requirement on Providers

The requirement that abortion providers delay performing or inducing a desired abortion for a patient until at least 24 hours after they have provided the state-mandated information is

extremely distressing for Plaintiffs. Physicians have an ethical duty to act in accordance with their patients' best interests and to respect their patients' autonomy. *E.g.*, Burkons Aff. ¶ 40; Haskell Aff. ¶ 35. The Waiting Period Requirement puts providers in the stressful position of having to depart from those duties and the standard of care by denying patients time-sensitive care for a specified minimum period of time, thereby risking harm to their patients' health and well-being. Romanos Aff. ¶¶ 38, 56–57, 68; Haskell Aff. ¶ 34.

Plaintiffs and clinic staff are also placed in the difficult position of being blamed for the forced delay, with many patients taking their frustrations out on the provider. Romanos Aff. ¶ 79; Haskell Aff. ¶ 35. Patients often react with anger and surprise when told they have to wait at least an additional 24 hours to access health care that they have already decided they need. Romanos Aff. ¶ 79 ("Patients tell me, you shouldn't make women wait this long; you shouldn't make us come back for so many appointments. Often, they assume I am to blame for this * * *"); Burkons Aff. ¶ 33 (describing a patient who repeatedly expressed frustration at the state-mandated delay that forced her to have a procedural rather than medication abortion). This can take a heavy emotional toll on providers and staff, and it undermines the patient-physician relationship, which is built on trust. Haskell Aff. ¶¶ 34–35; Burkons Aff. ¶ 23; Romanos Aff. ¶ 35.

2. The In-Person Requirement

a. Impact of the In-Person Requirement on Patients

The In-Person Requirement is derived from R.C. 2317.56, which requires the patient to receive certain state-mandated information "in person" during their first visit to an abortion provider, and from R.C. 2919.192, 2919.193, and 2919.194, which require the provider to test for embryonic and fetal cardiac activity—something that can only be done in person—during that initial visit as well. As a result of these mandates, the vast majority of patients in Ohio must make

at least two trips to the clinic in order to receive abortion care.[6] Like the other Challenged Requirements, the In-Person Requirement serves no medical purpose and needlessly burdens Ohio patients, while stigmatizing and interfering with their decision to have an abortion.

To attend even one appointment at one of Plaintiffs' health centers, patients must often arrange time off work—which, for those who do not have paid time off, can mean forgoing wages—and arrange and pay for childcare and transportation,[7] on top of ensuring they have the funds to cover the cost of their medical care. Burkons Aff. ¶ 29; Romanos Aff. ¶ 44; Haskell Aff. ¶ 23; Liner Aff. ¶¶ 13, 29, 31; Krishen Aff. ¶¶ 16, 19. Some patients must deal with the added complexity of bringing someone to travel with them to the abortion clinic, for example because they cannot drive themselves home after receiving sedation. Romanos Aff. ¶ 47. For many patients, particularly those who are living paycheck to paycheck, these costs are incredibly onerous to cover just once; requiring these patients to cover them twice (or more) in order to make additional unnecessary trips to the clinic can be devastating. Burkons Aff. ¶ 29; Haskell Aff. ¶ 23; Krishen Aff. ¶ 19; Liner Aff. ¶ 29; Maple Aff. ¶ 33; Romanos Aff. ¶ 45. Indeed, when told that they have to return to the clinic for a second appointment in order to receive care, some patients become distraught and even express concerns about being fired from their jobs for missing more work. Burkons Aff. ¶ 29.

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[6] A minority of patients receiving medication abortion are able to make only one trip to their abortion provider to receive both the state-mandated information and the abortion medication, which is provided in a lockbox that the patients take home with them and do not open until they are given the access code by their provider during a telehealth appointment at least 24 hours later. Burkons Aff. ¶ 21 n.1; Krishen Aff. ¶ 15. This option is not available for many patients, however, including all those who are past the 10 week LMP cut-off for medication abortion in Ohio. *Id.*

[7] As noted above, the majority of abortion patients have already given birth at least once and therefore many have existing children they need to account for in arranging medical appointments, *see supra* Section II.A, and even patients who live relatively near to a clinic may not have easy access to public or private transportation, Krishen Aff. ¶ 12.

Making two or more trips to a clinic is particularly onerous for some groups of patients. Given the limited number of abortion clinics (both within Ohio and nationally), Plaintiffs' patients travel from near and far to obtain abortion care, including from distant parts of Ohio and from out of state. Burkons Aff. ¶ 8; Haskell Aff. ¶ 23; Krishen Aff. ¶ 12; Liner Aff. ¶ 28; Romanos Aff. ¶ 41.[8] In addition to covering all of the costs already mentioned above (i.e., lost wages, childcare, transportation), these patients may also have to find a way to pay for food and lodging if an overnight stay is required given the travel distance. Burkons Aff. ¶ 28; Haskell Aff. ¶ 23; Liner Aff. ¶ 28; Maple Aff. ¶ 33. Indeed, people who are struggling to make ends meet may not even be able to afford a place to stay overnight: One patient was forced to sleep in her car in a McDonald's parking lot during the 24-hour wait between her first and second appointments because she had no other options for lodging. Romanos Aff. ¶ 48.

The In-Person Requirement is also particularly burdensome for patients facing intimate partner violence, who may need to conceal not one, but two or more clinic visits from an abusive partner, amplifying the risk to their security and physical safety. Haskell Aff. ¶ 24; Krishen Aff. ¶ 17; Liner Aff. ¶ 30; Maple Aff. ¶ 31; Romanos Aff. ¶ 66. Patients experiencing homelessness also struggle to attend one visit, let alone two, given their usual lack of childcare, reliable transportation, a secure place to store belongings, and access to a phone or the internet for scheduling and rescheduling appointments. Krishen Aff. ¶ 18.

[8] This is particularly true given that, since the U.S. Supreme Court's ruling in *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215, 142 S.Ct. 2228, 213 L.Ed.2d 545 (2022), several states bordering or near Ohio have entirely banned, or severely restricted, abortion. *See Tracking Abortion Bans Across the Country*, N.Y. Times (updated Jan. 8, 2024), https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html (accessed Mar. 28, 2024).

The In-Person Requirement only reinforces and compounds the harms created by the Waiting Period Requirement, as patients may be pushed later into their pregnancies and forced to delay care for multiple days or even weeks as they struggle to overcome the logistical and financial hurdles associated with attending a second appointment. For some patients, the costs and burdens associated with making a second trip to the clinic may be too high a barrier, and they may be forced to remain pregnant and carry to term against their will. Romanos Aff. ¶ 68; Haskell Aff. ¶ 22; Liner Aff. ¶ 26. Even worse, all of these burdens may not only be doubled but tripled if, as a result of the unnecessary delay, a patient is pushed into needing a two-day procedural abortion instead of a one-day procedure, or if embryonic or fetal cardiac activity is detected for the first time at the second visit, thus triggering an additional 24 hour waiting period. Romanos Aff. ¶ 43; Maple Aff. ¶ 36; Haskell Aff. ¶¶ 26, 54; *see* R.C. 2919.194(A).

Again, there is no medical justification for requiring patients to make two trips to a clinic, and far from advancing or improving patient health, forcing patients to make an unnecessary additional trip only further delays their access to time-sensitive care, risking harm to their health and well-being. Burkons Aff. ¶ 40; Romanos Aff. ¶¶ 56, 57, 78; Natl. Academies Report 77–78.

b. Impact of the In-Person Requirement on Providers

The In-Person Requirement also burdens Plaintiffs as abortion providers, and interferes with their ability to provide compassionate, timely abortion care to their patients, in accordance with the standard of care. It is deeply upsetting to Plaintiffs and their staff to be forced to act contrary to medical ethics and their best medical judgment in sending patients away for no medical reason, knowing that many of them will struggle to return or even forgo necessities in order to make a second, medically unnecessary trip to the clinic, and that their access to time-sensitive medical care will be further delayed, risking harm to their health and well-being. Krishen Aff. ¶ 28; Maple Aff. ¶ 30; Romanos Aff. ¶ 79. Moreover, by forcing Plaintiffs to schedule each patient

for additional, unnecessary in-person appointments, the In-Person Requirement imposes unnecessary constraints on Plaintiffs' ability to efficiently manage their schedules in order to accommodate the large numbers of patients in need of their care, including the influx of patients traveling from out of state. Burkons Aff. ¶ 8; Haskell Aff. ¶ 23; Krishen Aff. ¶¶ 12, 29; Liner Aff. ¶ 40; Romanos Aff. ¶ 41.

3. State Information Requirement

a. Impact of the State Information Requirement on Patients

The State Information Requirement imposes additional burdens on patients accessing abortion care by forcing upon them irrelevant, unnecessary, stigmatizing and, in some instances, misleading information that has nothing to do with their medical care. Burkons Aff. ¶ 40; Romanos Aff. ¶ 13. In so doing, the State Information Requirement affirmatively harms and distresses patients. For example, for couples who are struggling with terminating a deeply wanted pregnancy, being offered the opportunity to listen to cardiac activity and view images of healthy fetal development, as well as being forced to receive information regarding the probability of carrying a healthy pregnancy to term, can cruelly compound their grief. Haskell Aff. ¶ 31; Romanos Aff. ¶ 62. Some patients have struggled through difficult and costly rounds of in vitro fertilization only to learn of a serious fetal condition, making it even more difficult and painful to receive this information. Romanos Aff. ¶ 62. The State Information Requirement also forces patients who were sexually assaulted to relive the trauma of their assault, as the State needlessly requires their providers to inform them of the gestational age of the pregnancy, thereby reminding them of the date of their assault. Romanos Aff. ¶ 74; Haskell Aff. ¶ 31.

The requirements that patients be informed of the existence of embryonic or fetal cardiac activity, offered an opportunity to see or hear it, and then provided with statistics on the probability of carrying to term based on gestational age are not necessary for informed consent and serve no

medical purpose. Romanos Aff. ¶ 71. Rather, they serve only to stigmatize and shame patients for their decision and make them feel that their medical providers and the State disagree with their decision to have an abortion. Burkons Aff. ¶ 39; Maple Aff. ¶ 39. The state-mandated information suggests to patients that they are unable to arrive at their own health care decisions without the State intervening to tell them what information to consider, echoing outmoded stereotypes about women as selfish, irrational, and impulsive. Haskell Aff. ¶ 19; Maple Aff. ¶ 38; Romanos Aff. ¶ 38. Patients feel hurt and betrayed by their providers, whom they should trust, for forcing them to receive irrelevant and harmful information. Krishen Aff. ¶ 27; Maple Aff. ¶ 41 Romanos Aff. ¶ 79.

In addition to causing distress to patients, some of the state-mandated information is misleading. For example, it is not evidence-based medical practice to advise patients of their chances of carrying a pregnancy to term based solely on gestational age, as there are no reliable general statistics on this, and patient-specific factors (such as, for example, a history of prior cesarean sections) are relevant to this determination. Romanos Aff. ¶ 71. Providing patients with this type of misleading and inaccurate information that is irrelevant to their decision only risks confusing and upsetting them.

Indeed, major medical organizations like ACOG and the AMA agree that informed consent should involve shared decision-making, which is a "patient-centered, individualized approach" to the process. Am. Coll. of Obstetricians & Gynecologists, Committee on Ethics, Op. No. 819 (Feb. 2021), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/02/informed-consent-and-shared-decision-making-in-obstetrics-and-gynecology (accessed Mar. 28, 2024). Accordingly, ACOG opposes laws that require "state-mandated consent forms" or "require physicians to give, or withhold, specific information when counseling patients before undergoing

an abortion," because these laws burden and impair physicians' ability to fulfill their "ethical obligation to provide each patient with information that is evidence-based, tailored to that patient, and comprehensive enough to allow that patient to make an informed decision about care and treatment." *Id.* Likewise, the National Academies of Sciences, Engineering, and Medicine, a nonprofit organization established by Congress to provide independent, objective advice on policy relating to science, engineering, and medicine, has recognized that the "[l]ong-established ethical and legal standards for informed consent in health care appear to have been compromised" by abortion-specific regulations requiring patients to be given certain unnecessary state-mandated information, including information that may be misleading, before receiving an abortion. Natl. Academies Report 78.

In sum, the informed consent process should be flexible and tailored to the patient, not one-size-fits-all like the State Information Requirement demands. Romanos Aff. ¶ 26. Ohio's arbitrary, inflexible laws burden patients and interfere with their decision-making by forcing physicians to provide them with irrelevant, sometimes misleading, and stigmatizing information, while failing entirely to comport with the standard of care and the doctrine of informed consent.

b. Impact of State Information Requirement on Providers

Being forced to recite and provide the same information to every patient, regardless of their individual circumstances, is likewise distressing and upsetting for providers, as it is contrary to the standard of care and informed consent practice and only serves to undermine the patient-physician relationship of trust. Romanos Aff. ¶ 78; Burkons Aff. ¶ 40. Under the State Information Requirement, providers are compelled to give patients information that they know, based on their experience and medical judgment, is not supported by medical informed-consent best practices, and may instead be upsetting and/or misleading. As Plaintiff Dr. Romanos explains, "It often feels like the state has deliberately placed a wall between me and my patients, preventing me from

providing the best medical advice and care possible." Romanos Aff. ¶ 78. The State Information Requirements thereby turn physicians into mouthpieces for the State, denying them the ability to exercise their professional judgment when they provide abortions—and only when they provide abortions. Romanos Aff. ¶ 77 ("[U]nder Ohio's current abortion laws, I am not able to use my best medical judgment * * *. I feel like I am trusted to be a doctor when I provide any other medical care, but not when I'm providing an abortion."); Liner Aff. ¶ 41 ("As a health care provider, it is my duty to obtain informed consent from patients—I don't need the state to mandate this.").

III. LEGAL STANDARDS

A. Preliminary Injunction Standard

A preliminary injunction should be granted where the moving party demonstrates that: (1) "there is a substantial likelihood that plaintiff will prevail on the merits"; (2) "plaintiff will suffer irreparable injury if the injunction is not granted"; (3) third parties will not "be unjustifiably harmed if the injunction is granted"; and (4) "the public interest will be served by the injunction." *Vanguard Transp. Sys., Inc. v. Edwards Transfer & Storage Co.*, 109 Ohio App.3d 786, 790, 673 N.E.2d 182 (10th Dist.1996) (citing *Valco Cincinnati, Inc. v. N&D Machining Serv., Inc.*, 24 Ohio St.3d 41, 492 N.E.2d 814 (1986) and *Goodall v. Crofton*, 33 Ohio St. 271 (1877)).

B. Ohio's Robust Constitutional Right to Reproductive Freedom

Ohioans enshrined a robust, affirmative right to reproductive freedom in the Ohio Constitution that protects Ohioans from any effort to "directly or indirectly[] burden, penalize, prohibit, interfere with, or discriminate against" them exercising their right to reproductive freedom. Ohio Constitution, Article I, Section 22(A)–(B). The Amendment similarly protects a person or entity assisting Ohioans in exercising that right. *Id.*

The constitutional amendment specifies that the State may impose restrictions on abortion *only* if it can demonstrate that, in doing so, it is using "the least restrictive means to advance the

individual's health in accordance with widely accepted and evidence-based standards of care." *Id.* In analyzing the Amendment, Attorney General David Yost, a defendant in this case, explained that it imposes a more stringent test on abortion restrictions than the "strict scrutiny" test announced in *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973), or the "undue burden" test discussed in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 112 S.Ct. 2791, 120 L.Ed.2d 674 (1992). *Issue 1 on the November 2023 Ballot: A Legal Analysis by the Ohio Attorney General* 5–7 (Oct. 5, 2023) https://www.ohioattorneygeneral.gov/SpecialPages/FINAL-ISSUE-1-ANALYSIS.aspx (accessed Mar. 29, 2024); *see also id.* at 6–7 (explaining "'least restrictive means' requirement is even stricter than the already-strict 'narrow tailoring' requirement").

IV. ARGUMENT

A preliminary injunction is necessary and appropriate to stop the ongoing constitutional, medical, emotional, financial, psychological, and other harms currently being inflicted upon Plaintiffs and their patients by the Challenged Requirements, and Plaintiffs have amply demonstrated that they satisfy all four factors necessary for obtaining such relief. First, Plaintiffs have a substantial likelihood of success on the merits. As discussed below, the Challenged Requirements serve only to burden, penalize, interfere with, discriminate against, and in some cases prohibit Ohioans' exercise of their right to abortion care, and Plaintiffs' ability to assist them in doing so. At the same time, the Challenged Requirements do nothing to further patient health (let alone through the least restrictive means); to the contrary, they actively harm patient health and well-being by, *inter alia*, subjecting patients to heightened medical risks associated with delayed access to time-sensitive care. The State thus cannot carry its heavy burden under the extremely protective standard the Amendment created. Second, enforcement of the Challenged Requirements has continuously inflicted serious and irreparable harms on people in Ohio trying to

access constitutionally protected abortion care and on Plaintiffs, as abortion providers seeking to assist them. Finally, no third parties will be harmed by the order and the public is served by the issuing of the preliminary injunction sought. Plaintiffs therefore urge the Court to issue a preliminary injunction.

A. Plaintiffs Have a Substantial Likelihood of Succeeding on the Merits of Their Claim That the Challenged Requirements Violate Patients' and Providers' Rights Under the Amendment.

As detailed below, Plaintiffs have shown that, individually and collectively, the Challenged Requirements burden, interfere with, penalize, discriminate against, and in some cases prohibit patients in exercising their right to abortion and providers in assisting them in doing so. Accordingly, in order for the Requirements to survive scrutiny under Article 1, Section 22, Defendants bear the heavy burden of proving that the Requirements constitute the least restrictive means of advancing patient health in accordance with widely accepted and evidence-based standards of care. Defendants cannot possibly satisfy that burden here, where the evidence also shows that, far from providing any benefit to patient health, the Requirements only harm patient health and well-being. Accordingly, Plaintiffs are more than substantially likely to succeed on the merits of their claim.

1. The Waiting Period Requirement Violates the Constitutional Right to Abortion.

a. The Waiting Period Requirement Burdens, Penalizes, Interferes with, Discriminates Against, and in Some Cases Prohibits Patients from Making and Carrying out Their Own Reproductive Decisions.

As discussed above in Section II.D.1.a., by forcing all patients—including those who are certain in their decision—to wait at least 24 hours to receive abortion care, if not much longer, the Waiting Period Requirement burdens and interferes with Ohioans' reproductive decisions and penalizes them for choosing abortion. For example, patients forced to remain pregnant by the

Waiting Period Requirement have to endure the physical and emotional stress of remaining pregnant against their will; contend with increased risks of complications from the pregnancy itself; risk having to undergo a more complex and/or expensive abortion; and in some cases delay other necessary care, such as cancer treatment. *See supra* Section II.D.1.a.

The Waiting Period Requirement may also effectively prohibit a patient from receiving their preferred form of abortion, or from having an abortion at all. *Id.* For patients approaching 10 weeks LMP—the cutoff for medication abortion—delay can mean that their only remaining option by the time they are able to return to the clinic for care is a procedural abortion. *Id.* For others, the delay in care can prohibit them from obtaining an abortion in Ohio altogether, either because their pregnancy has advanced past the legal limit, or the obstacles to returning for a second visit are too steep to overcome. *Id.*; *see also Hodes & Nauser MDS PA v. Kobachm*, Kan.Dist.Ct. No. 23CV03140, 2023 WL 7130406, at *21 (Oct. 30, 2023) ("Delays, such as those contemplated by the Act, increase the costs, logistics, and risks to the pregnant woman seeking to avail herself of her fundamental rights, and likely decrease or eliminate access to these services * * *."). Finally, the Waiting Period Requirement discriminates against abortion patients, singling them out for the differential and disfavor able treatment by imposing a mandatory waiting period only on patients seeking abortion care, while those seeking any other similarly time-sensitive medical care or treatment in Ohio can receive care without state-imposed delay. *See supra* Section II.D.1.a.

b. The Waiting Period Requirement Burdens, Penalizes, Interferes with, Discriminates Against, and in Some Cases Prohibits Providers from Assisting Their Patients in Obtaining Abortion Care.

Without the Waiting Period Requirement, Plaintiffs and other abortion providers would provide the prompt, evidence-based care that they know their patients desire and need. Instead, the Waiting Period Requirement forces providers to delay providing time-sensitive health care, and,

in so doing, to act contrary to the standard of care, their ethical duties, and their professional judgment, which all dictate that patients should be provided with abortion care without unnecessary delay in order to avoid harm to the patients' health and well-being. *See supra* Section II.D.1.b. The Waiting Period Requirement also drives a wedge between Plaintiffs and their patients and forces Plaintiffs to inflict unnecessary emotional and psychological pain on their patients by delivering the stigmatizing, hurtful message that they have to be treated differently solely because they need abortion care. *Id.* This in turn interferes with providers' abilities to successfully do their jobs: provide medical care to patients. *Id.*

Additionally, the Waiting Period Requirement discriminates against abortion providers by forcing only them to delay time-sensitive care for their patients, while leaving other medical providers free to follow their own medical judgment and standard of care by providing prompt and compassionate care to their patients. *Id.* Ohio does not mandate a delay like the Waiting Period Requirement for any other similarly time-sensitive medical procedure, treatment, or surgery—not even, most tellingly, for identical procedures when used for miscarriage treatment. *Id.*

c. The Waiting Period Requirement Does Not Advance Patient Health.

Given the burdens, interference, penalties, and discrimination imposed on abortion patients and providers by the Waiting Period Requirement, it is subject to the extremely exacting scrutiny imposed by the Amendment—which it cannot survive. As discussed above, the medical consensus is that mandatory waiting or delay periods for abortion harm patient health and well-being. *See supra* Section II.D.1.a. Unnecessarily delaying time-sensitive abortion care subjects patients to continued risks associated with pregnancy and increased incremental risk associated with obtaining an abortion later. *Id.*; *see also, e.g.*, *Planned Parenthood of Middle Tennessee v. Sundquist*, 38 S.W.3d 1, 23–24 (Tenn.2000) (observing that risks increase with gestational age and

that "[s]tudies also suggest that a large majority of women who have endured waiting periods prior to obtaining an abortion have suffered increased stress, nausea and physical discomfort"). Subjecting patients to such unnecessary risks is contrary to the standard of care and evidence-based practice of medicine, and does nothing to further informed consent. *See supra* Section II.D.1.a. Given this, the State cannot possibly meet its heavy burden of showing that the Mandatory Delay Requirement advances patient health "in accordance with widely-accepted and evidence based standards of care," let alone that it is the least restrictive means of doing so.

2. The In-Person Requirement Violates the Constitutional Right to Abortion.

a. The In-Person Requirement Burdens, Penalizes, Interferes with, Discriminates Against, and in Some Cases Prohibits Patients from Making and Carrying out Their Own Reproductive Decisions.

Without any medical justification, the In-Person Requirement forces the vast majority of patients to make unnecessary additional and often lengthy trips to a clinic to receive an abortion. In so doing, as detailed above in Section II.D.2.a, the In-Person Requirement risks subjecting patients to, *inter alia*, physical or emotional harms associated with being forced to delay their abortion and remain pregnant longer; potentially unmanageable expenses and/or other logistical hurdles associated with unnecessary travel; and physical harm from a violent partner who—as a result of the additional delay and unnecessary trip—may discover the patient's pregnancy and/or abortion intentions. *See supra* Section II.D.2.a. The In-Person Requirement also exacerbates the delay already imposed by the Waiting Period Requirement, as many patients need additional time to arrange logistics and/or amass funds for a second (or third) trip, thereby amplifying the risks to their health and well-being and, for some, possibly pushing them past the point of obtaining abortion in Ohio entirely. *Id.*; *Planned Parenthood of Middle Tennessee*, 38 S.W.3d at 24 ("[B]ecause the waiting period requires a woman to make two trips to the physician, the waiting

period is especially problematic for women who suffer from poverty or abusive relationships."). Finally, the In-Person Requirement discriminates against abortion patients by mandating that they alone make a separate in-person visit to obtain certain state-mandated information in advance of receiving care, while requiring this of no other Ohio patients seeking other medical care. *See supra* Section II.D.2.a.

b. The In-Person Requirement Burdens, Penalizes, Interferes with, Discriminates Against, and in Some Cases Prohibits Providers from Assisting Their Patients in Obtaining Abortion Care.

The In-Person Requirement compels providers to act contrary to their professional judgment and the evidence-based standard of care by forcing their patients to make additional trips to the clinic for an abortion, thereby exacerbating unnecessary delay and risking harm to patient health. *See supra* Section II.D.2.b. The In-Person Requirement also interferes with abortion providers' relationships with their patients, since providers must, without any medical justification, turn their patients away and force them to make a second trip to the clinic for care, even when patients are resolute that they want an abortion now and are concerned about their ability to return to the clinic and receive the care they need. *Id.* The In-Person Requirement thus forces providers to inflict unnecessary emotional and psychological pain on their patients. *Id.* And again, it imposes all of these unnecessary and burdensome requirements on medical professionals who provide abortion care only, thereby discriminating against them based on the type of health care they provide. *Id.*

c. The In-Person Requirement Does Not Advance Patient Health.

As with the Waiting Period Requirement, medical consensus is clear that "[s]tate regulations that require [patients] to make multiple in-person visits and wait multiple days delay the abortion," and delaying abortion only risks harm to the patient. Natl. Academies Report 78; *see supra* Section II.D.2.a. Such requirements have no medical justification, are not necessary for

informed consent, are contrary to medical ethics, and only serve to further harm and stigmatize abortion patients. *See supra* Section II.D.2.a. Accordingly, the State cannot meet its heavy burden of justification, and the In-Person Requirement cannot survive scrutiny under the Amendment.

3. The State Information Requirement Violates the Constitutional Right to Abortion.

a. The State Information Requirement Burdens, Penalizes, Interferes with, and Discriminates Against Patients Making and Carrying out Their Own Reproductive Decisions.

The State Information Requirement forces patients to receive one-size-fits-all information that is irrelevant, stigmatizing, and in some cases misleading. *See supra* Section II.D.3.a. In so doing, it burdens, penalizes, interferes with, and discriminates against patients in exercising their right to make and carry out their own decisions concerning abortion, the overwhelming majority of whom are already confident in their decisions when they arrive at a clinic. *Id.*

As explained above, informed consent involves educating the patient on the nature and purpose of the contemplated medical treatment or procedure, as well as its risks, benefits and alternatives, and requires a collaborative, individualized and flexible process built around the patient's specific questions, needs, concerns, and circumstances. *See supra* Section II.C.1. Most patients seeking abortion care in Ohio arrive at a clinic already confident in their decision to proceed with an abortion. *See supra* Section II.C.2. Forcing irrelevant, untailored, and sometimes inaccurate information about fetal or embryonic cardiac activity upon patients who have already decided to end their pregnancies does nothing to further informed consent. *See supra* Section II.D.3.a.; *Hodes & Nauser*, 2023 WL 7130406, at *20 (striking down one-size-fits-all information requirement). Instead, it leaves them feeling like the State and, in turn, their trusted medical providers, disapprove of their decision. *See supra* Section II.D.3.a.

The State Information Requirement can also be deeply harmful to patients' emotional and psychological wellbeing, particularly for patients already experiencing trauma. For example, reminding patients who are ending pregnancies resulting from sexual assault, rape, or incest of the embryo's or fetus's gestational age is not only unnecessary, it also may serve to upset the patient by forcing them to recall the date they were attacked. *Id.* Likewise, informing patients who are terminating wanted pregnancies due to a fetal diagnosis of the presence of fetal cardiac activity, and offering them the opportunity to listen to it, does nothing to further informed consent and may only deepen unimaginable grief. *Id.* Shaming and stigmatizing abortion patients in this way burdens and penalizes them for deciding to terminate their pregnancies and discriminates against them for doing so, as no patient seeking any other type of medical treatment is forced to receive irrelevant and potentially harmful information as a prerequisite for obtaining care. *Id.*

b. The State Information Requirement Burdens, Penalizes, Interferes with, and Discriminates Against Providers for Assisting Their Patients in Obtaining Abortion Care.

The State Information Requirement undermines Plaintiffs' informed consent practices and ethical duty to respect patient autonomy. It requires them to force upon their patients information that is irrelevant and/or misleading and serves only to stigmatize and harm. *See supra* Section II.D.3.b. As Plaintiffs attest, this is burdensome and upsetting to them as providers committed to providing compassionate, evidence-based health care. *Id.*

Given the legal and ethical requirements that already apply to all providers, *see supra* Section II.C.1., the medically unnecessary and ethically unsound State Information Requirement interferes with and burdens the patient-physician relationship of trust and prevents Plaintiffs from providing the best medical advice and care possible to their abortion patients. *Cf. Thornburgh v. Am. College of Obstetricians & Gynecologists*, 476 U.S. 747, 802, 106 S.Ct. 2169, 90 L.Ed.2d 779 (1986) (finding the information required to be provided to abortion patients was plainly designed

to intrude upon provider discretion). This is especially true given Plaintiffs' robust practices that meet and exceed informed consent requirements. *See supra* Section II.C.2. Further, the State Information Requirement is discriminatory, as no other provider of medical care is subject to state-imposed penalties for failing to provide medically irrelevant and potentially harmful and misleading information to their patients. *See supra* Section II.D.3.b.

c. The State Information Requirement Does Not Advance Patient Health.

Because of the burdens and penalties it imposes on abortion providers and patients, the State Information Requirement must also be closely scrutinized. Yet again, medical consensus is clear: the ethical obligations of informed consent require that patients be provided with information that is necessary and relevant to their decision-making and that their autonomy be respected, necessitating an individualized approach that accounts for each patient's values and priorities. *See supra* Section II.D.3.a. The State Information Requirement dramatically departs from this, instead mandating that medical providers force upon their patients unnecessary and irrelevant information that utterly fails to account for the patient's individual medical or social circumstances, values, or priorities. *Id.* This not only undermines informed consent and medical ethical principles, but also risks affirmatively harming or distressing patients. *Id.* It therefore cannot pass constitutional muster.

B. Plaintiffs and Their Patients Are Suffering Irreparable Harm.

Every day since the Amendment took effect, Plaintiffs' patients' constitutional rights are being violated. It is well established that the violation of constitutional rights is, in and of itself, an irreparable harm. *See Magda v. Ohio Elections Comm.*, 2016-Ohio-5043, 58 N.E.3d 1188, ¶ 38, (10th Dist.) ("A finding that a constitutional right has been threatened or impaired mandates a finding of irreparable injury * * *." (citing *Bonnell v. Lorenzo*, 241 F.3d 800, 809 (6th Cir.2001)));

Michigan State A. Phillip Randolph Inst. v. Johnson, 833 F.3d 656, 669 (6th Cir.2016) ("[W]hen constitutional rights are threatened or impaired, irreparable injury is presumed." (citation omitted)); *Obama for Am. v. Husted*, 697 F.3d 423, 436 (6th Cir.2012); *see also ACLU of Kentucky v. McCreary Cty., Kentucky*, 354 F.3d 438, 445 (6th Cir.2003) (citing *Elrod v. Burns*, 427 U.S. 347, 373, 96 S.Ct. 2673, 49 L.Ed.2d 547 (1976)). Because Plaintiffs' patients' constitutional rights under the Amendment are being violated each day that the Challenged Requirements remain in effect, they currently suffer and will continue to suffer irreparable injury if the challenged provisions are not enjoined.

On top of this, due to the Challenged Requirements, Plaintiffs' patients are suffering harms to their physical and mental health and dignity that are not compensable or remediable at law. *See Doe v. Barron*, 92 F.Supp.2d 694, 696 (S.D.Ohio 1999) (finding irreparable harm from delay of incarcerated plaintiff's abortion procedure); *see also Taverns for Tots, Inc. v. City of Toledo*, 307 F.Supp.2d 933, 945 (N.D.Ohio 2004) (recognizing that harm to health constitutes irreparable harm); *Doe v. Franklin Cty. Children's Servs*., S.D.Ohio No. 2:20-CV-4119, 2020 WL 4698801, at *3 (Aug. 13, 2020) (weighing "serious harm to [individuals'] health or wellbeing absent injunctive relief" in finding irreparable harm); *Bd. of Edn. of Highland Local School Dist. v. United States Dept. of Edn.*, 208 F.Supp.3d 850, 878 (S.D.Ohio 2016) (finding stigma to be a type of irreparable harm). In addition to all of the harm patients experience from being delayed access to time-sensitive care, *see supra* Section II.D.1.a., being forced to make two or more trips to the clinic, *see supra* Section II.D.2.a., and being forced to receive irrelevant and distressing information, *see supra* Section II.D.3.a., patients who are prevented exercising their constitutional right to access abortion in Ohio by virtue of the Challenged Requirements will suffer irreparable harm in the form of forced pregnancy and childbirth. *Barron*, 92 F.Supp.2d at 696. Additionally,

Plaintiffs themselves have suffered and will continue to suffer the emotional and moral distress that arises from being forced to act contrary to the standard of care, evidenced-based medical practice, and their ethical duties, and the ensuing loss of their patients' trust. *See supra* Sections II.D.1.b, 2.b, 3.b.

C. Other Factors Weigh in Favor of Granting Plaintiffs' Motion.

Enjoining the Challenged Requirements will not harm third parties, and stopping both the violation of people's constitutional rights in Ohio and the other concrete and irreparable harms associated with the Requirements serves the public interest. First, the State will not suffer any harm from an injunction, as none of the Challenged Requirements furthers the only state interest that is relevant under the Amendment, an interest in patient health; instead the Requirements only impair patient health and well-being and violate Ohioans' constitutional rights. *See supra* Sections II.D.1.a, 2.a., 3.a. Second, "a great[] public interest exists in ensuring governments and governmental officials operate within the confines of constitutional restrictions and prohibitions," and as such, "it is always in the public interest to prevent violation of a party's constitutional rights." *Lamar Advantage GP Co. v. City of Cincinnati*, Hamilton C.P. No. A-18-04105, 114 N.E.3d 805, 829 (Oct. 17, 2018), quoting *Miller v. City of Cincinnati*, 709 F.Supp.2d 605, 627 (S.D.Ohio 2008); *Am. Freedom Defense Initiative v. Suburban Mobility Auth. for Regional Transp.*, 698 F.3d 885, 896 (6th Cir.2012) ("[T]he public interest is promoted by the robust enforcement of constitutional rights * * *"); *G & V Lounge, Inc. v. Michigan Liquor Control Comm.*, 23 F.3d 1071, 1079 (6th Cir.1994). Because a preliminary injunction against the Challenged Restrictions will prevent future violation of Plaintiffs' patients' rights under Article I, Section 22, it is clearly in the public interest.

D. The Injunction Should Issue Without Bond.

This Court has wide discretion under Civil Rule 65(C) to set a preliminary injunction bond, including by waiving it altogether. *Vanguard Transp. Sys.*, 109 Ohio App.3d at 793, 673 N.E.2d 182; *see also Moltan Co. v. Eagle-Picher Industries, Inc.*, 55 F.3d 1171, 1176 (6th Cir.1995) (affirming decision to require no bond because of "the strength of [the plaintiff's] case and the strong public interest involved"). The Court should use that discretion to waive the bond requirement here, where the relief sought will result in no monetary loss to Defendants.

V. CONCLUSION

For the foregoing reasons, Plaintiffs ask this Court to issue a preliminary injunction enjoining Defendants, their agents, employees, servants, and successors, and any persons in active concert or participation with them, from enforcing R.C. 2317.56, 2919.192, 2919.193, 2919.194.

Respectfully submitted,

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**Motions for pro hac vice forthcoming*

CERTIFICATE OF SERVICE

I hereby certify that on March 29, 2024 a copy of the foregoing was electronically filed via the Court's e-filing system. I further certify that a copy of the foregoing was served by email upon the following parties:

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IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

PRETERM-CLEVELAND, *et al.*, *Plaintiffs*, v. DAVE YOST, *et al.*, *Defendants.*	Case No. Judge

AFFIDAVIT OF DR. SHARON LINER IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Dr. Sharon Liner, having been duly sworn and cautioned according to law, hereby state that I am over the age of 18 years and am competent to testify as to the facts set forth below based on my personal knowledge:

1. I am the Medical Director of Planned Parenthood Southwest Ohio Region ("PPSWO"), a Plaintiff in this case. I am also PPSWO's Director of Surgical Services, a position I have held for nearly 17 years. I have worked as a physician for PPSWO since 2004. Throughout that time, I have provided sexual and reproductive health care, including abortion, to our patients.

2. I submit this affidavit in support of Plaintiffs' Motion for a Preliminary Injunction to block the enforcement of Ohio Revised Code Sections 2317.56 and 2919.192–194 (collectively, the "Challenged Requirements"). I am familiar with the Challenged Requirements because I have complied with them in my practice and, in my current role, it is my responsibility to ensure that the physicians, clinicians, and other staff that I supervise at PPSWO comply with them as well. I understand that these laws require physicians to provide certain state-mandated information to patients seeking abortion, both in person and at least 24 hours before the physician can provide the abortion. In my medical experience, forcing patients to delay abortions that they already know

they want and to make two trips to our clinic is incredibly burdensome to patients, prevents some abortions and increases health risks for others, and interferes with the practice of medicine.

3. The facts I state here are based on my experience, information obtained in the course of my duties at PPSWO, including my review of PPSWO business records, and personal knowledge that I have acquired through my service at PPSWO.

I. My Background

4. I am a board-certified family physician with 20 years of experience in women's health. I am licensed to practice medicine in the state of Ohio. I earned a Bachelor of Science in Medical Technology from Michigan State University and graduated from medical school at Michigan State University, College of Human Medicine. I completed my residency in Family Medicine at the University of Cincinnati.

5. Since 2002, I have provided abortions in outpatient settings. In my current practice, I provide medication abortions through 70 days (10 weeks) of pregnancy, as measured from the first day of a patient's last menstrual period ("LMP"), and procedural abortions through 21 weeks, 6 days LMP.

6. In my current roles as the Director of Surgical Services and Medical Director at PPSWO, I oversee all medical services that we provide, including abortion. My responsibilities include supervising the physicians and clinicians who provide care and the development of PPSWO's medical policies and procedures.

II. PPSWO and Its Services

7. PPSWO and its predecessor organizations have provided care in Ohio since 1929. PPSWO is a nonprofit corporation organized under Ohio state law and headquartered in Cincinnati, Ohio.

8. PPSWO provides affordable, respectful, and high-quality health care to tens of thousands of patients each year. PPSWO provides a broad range of medical services, including birth control; annual gynecological examinations; cervical pap smears; diagnosis and treatment of vaginal infections; testing and treatment for certain sexually transmitted infections; pregnancy testing; and abortion.

9. PPSWO operates five health centers in southwest Ohio: two in Cincinnati, and one each in Dayton, Hamilton, and Springfield. We provide abortions at our ambulatory surgical facility ("ASF") in Cincinnati.[1] PPSWO or a predecessor organization has provided abortions in this location since 1974.

III. Abortion Provision at PPSWO

10. There are two methods of abortion: medication abortion and procedural abortion. Both methods of abortion are effective in terminating a pregnancy. PPSWO offers both methods.

11. The window during which a patient can obtain an abortion in Ohio is limited. Pregnancy is generally 40 weeks in duration, but Ohio prohibits abortion beginning at 22 weeks LMP. PPSWO performs procedural abortion through 21 weeks, 6 days LMP. Ohio law presently allows medication abortion for the first 10 weeks of pregnancy LMP.[2] PPSWO provides medication abortion throughout this period.

[1] Under Ohio law, all procedural abortions must occur in a licensed ASF or a hospital, and the Cincinnati facility is PPSWO's only ASF. PPSWO's other four locations, which are health centers but not ASFs, provide a broad range of care but do not provide abortions.

[2] Current medical evidence demonstrates that medication abortion is safe and effective through at least 11 weeks of pregnancy LMP. However, Ohio law restricts the first drug used in medication abortion to use as described in the federally approved label, which is for pregnancies less than ten weeks. *See* U.S. Food & Drug Administration, *Mifeprex (mifepristone) Information* (last updated Feb. 5, 2018), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information (accessed March 26, 2024).

12. Our patients seek abortion for a multitude of complicated and personal reasons. For example, some patients have abortions because they conclude it is not the right time to become a parent or have additional children. Other patients lack the financial resources to support a child and/or do not have partner or familial support or stability. Other patients want to pursue their education or career. Some seek abortions because continuing with the pregnancy could pose a greater risk to their health.

13. Patients generally seek abortion as soon as they are able, but this does not always mean that patients receive care soon after learning they are pregnant. Many people face onerous logistical obstacles that can delay access to abortion services for weeks—or even months in some cases. Patients need to schedule an appointment, gather resources to pay for the abortion and related costs (such as travel and lodging),[3] and arrange transportation to a clinic, time off of work (often unpaid, due to a lack of paid time off or sick leave), and possibly child care during appointments. These tasks are not simple for many of our patients. For low-income patients, losing a day's wages or traveling to and from a clinic can be a substantial cost that requires time to plan and save.

IV. The Challenged Ohio Laws

14. I understand that Ohio law requires that a physician meet with a patient in person at least 24 hours before an abortion to provide the patient with certain state-mandated information and allow them to ask questions. That information includes the nature and purpose of the abortion, and any risks associated with it; the probable gestational age of the pregnancy; and the medical

[3] Ohio prohibits public insurance, including Medicaid, and insurance purchased on the state health exchange from covering abortion services except in the very limited circumstances where a patient's life is at risk, or where the pregnancy is a result of rape or incest that has been reported to law enforcement.

risks associated with continuing a pregnancy to term. The law also requires that at least 24 hours prior to the abortion, the patient be provided with the name of the physician intending to perform the abortion and copies of state-published materials concerning gestational development, family planning information, and information about agencies offering alternatives to abortion. Ohio law also requires that, prior to the abortion, the patient certify in writing that all of these requirements have been met, that all of their questions have been answered, and that they are consenting to the abortion. It is my understanding that there is a narrow exception to these requirements for cases of medical emergency or medical necessity. I further understand that failure to comply with these requirements may result in civil and/or disciplinary penalties.

15. I also understand that Ohio law mandates that before providing an abortion, a provider must first determine whether there is detectable embryonic or fetal cardiac activity. If such activity is detected, I understand that the law requires a provider to offer the pregnant person an opportunity to view or hear the cardiac activity. Moreover, if such activity is detected, the provider must inform the patient in writing that cardiac activity has been detected and the statistical probability of bringing the pregnancy to term based on gestational age, obtain from the patient a signed acknowledgment of receipt of this information, and then wait at least 24 hours before providing the abortion. I understand, in addition to civil and disciplinary penalties, a provider faces potential criminal prosecution for violating this law.

16. The Challenged Requirements force patients to delay their care by at least 24 hours and to make at least two separate trips to the abortion clinic in order to have an abortion.

V. Informed Consent and the State-Mandated Delay

17. The purpose of informed consent is to notify a patient of the intended procedure or treatment and advise them of the treatment's or procedure's nature, risks, benefits, and alternatives. I obtain informed consent from patients for any form of medical care I provide. This is true of all

providers at PPSWO—separate and apart from any statutorily imposed requirements, we always make sure that every patient understands and consents to their treatment, as doing so is a core component of medical care. Because this is the standard of care and critical from a medical ethics perspective, we would ensure informed consent for each of our patients regardless of whether there was a statutory obligation to do so.

18. For our patients seeking abortion, we always make sure that their decision is voluntary and informed. Our staff, including educators, nurses, and physicians, provide extensive education to patients. They explain the intended treatment or procedure to the patient, present a video explaining any potential side effects and risks associated with abortion care, and provide them with an opportunity to ask questions. They also review a patient's medical history and do bloodwork to determine whether the patient has any medical contraindications and to properly educate them on medical risks.

19. All our staff are trained to recognize signs of patient hesitancy. If a patient exhibits such signs, staff will question whether the patient is certain that they would like to proceed with the abortion and talk with them about any concerns. Our staff are trained regarding how to have these conversations in an open, empathetic manner, to help patients feel comfortable asking any questions and discussing any concerns with clinic staff. We ensure that through every step of the process, a patient can always take a step back, take more time to think about their decision, and reschedule an appointment for a later date, or decide not to continue with their abortion.

20. Our staff are also trained to recognize signs of coercion. We screen all patients, including abortion patients, for any form of coercion, including intimate partner violence ("IPV"), evaluating whether they are at immediate risk of harm and whether we can provide them resources to help them leave an abusive relationship. While patients may have someone accompany them

through portions of the informed consent process because many want to have that support, we recognize that sometimes the other person present may be a source of coercion. Because of this, we always ensure that patients have time alone with an educator or provider, so that they can express themselves more freely and ask questions honestly so that our staff can further assess for signs of coercion.

21. PPSWO never rushes a patient to make a decision about whether to have an abortion, or what type of abortion they want. Some patients want to gather information about having an abortion but are not yet firm in their decision to proceed. Sometimes patients are fairly certain of their decision to have an abortion but want to go home and talk it through with a loved one. Patients are always given the option to reschedule their appointment if they are not sure they want to proceed with an abortion at that time.

22. Even so, almost all the patients we see are certain that they want to have an abortion when they come to our clinic. They often express anger or frustration at having to wait another 24 hours and make another trip to the clinic before being able to obtain an abortion when they have already weighed their options and decided that that is the best decision for them.

23. All patients have spent time thinking about the decision of whether to have an abortion before they come to our clinic. The Challenged Requirements force us to tell patients, "Even though you know you are sure, you have to wait." This is degrading to patients, who are capable of making their own free choices—who know their bodies and know what they want. The degrading impact can be heightened when patients ask us what the medical benefit of the 24-hour delay is, and we have to tell them that there is no medical benefit—just a legal requirement. This is particularly true for patients who are suffering debilitating pregnancy symptoms and have to wait at least an additional 24 hours for no medical reason.

24. I am not aware of any other time-sensitive medical procedures that are subject to a similar, statutorily-imposed waiting period for informed consent or that require a separate, in-person visit for informed consent. PPSWO providers and staff always want to do what is best for a patient. What is best for each patient is not always the same because human beings and their care needs are individual; to have specific timelines mandated by the state does not make good medical sense.

VI. Impact of the Delay on Patients and Staff

25. The Challenged Requirements impose heavy burdens on PPSWO's patients by creating obstacles to obtaining an abortion without enhancing patient safety. These laws force patients to make at least two in-person visits to the clinic—the first to obtain the state-mandated information and the second at least 24 hours later for the abortion itself.

26. For some of our patients, it can be incredibly difficult to make two trips. For other patients, this obstacle is insurmountable, thus forcing them to remain pregnant for longer against their will or even carry a pregnancy to term.

27. Even for patients who live near the clinic, the Challenged Requirements can be very burdensome. Patients may have to take unreliable public transportation, cobble together rides from friends or family members, or figure out how to pay for a rideshare service. Having to make two trips to the clinic doubles the difficulty of getting there and is more likely to compromise a patient's privacy. When patients have to rely on others for transportation, child care, or to help cover the cost of the abortion, or have to ask for time off work, for example, they may be forced to disclose to an employer, friend, or family member that they are having an abortion.

28. We have patients who travel to our clinic for abortions from distant parts of Ohio. Because we are the nearest abortion provider for people from some parts of Indiana, Kentucky, and West Virginia—all of which ban abortion entirely—we see many out-of-state patients. In the

past year, we have seen patients from 16 states, including farther away states such as Florida and Georgia. For those patients traveling long distances, two clinic visits means either an overnight stay near the clinic or two separate trips to the clinic. Patients staying overnight must arrange and pay for travel and overnight accommodations.

29. Because many of our patients are already parents, they may need to arrange for child care to obtain an abortion, which may be an additional cost or require them to disclose their decision to have an abortion to someone else. Many patients also lose wages because they have to miss work and do not work in jobs that provide paid time off. These costs are substantial for patients living paycheck to paycheck and can mean the difference between buying groceries for their families that week or not. When patients have to make two separate trips to the clinic, these costs rise even further.

30. For patients experiencing IPV, the Challenged Requirements are more likely to compromise their privacy, which can put them in danger. Having to keep multiple visits confidential from an abusive partner puts them at risk of violence and retaliation.

31. In practice, the 24-hour delay is often drawn out further. Our patients are frequently juggling work or school schedules, child care, lack of transportation, and financial challenges paying for an abortion. Thus, it is often not feasible for them to have their abortion the day after their first appointment. For patients who already have to overcome these obstacles before their first visit to the clinic, the delay could easily turn into more than a week. Furthermore, even if the patient could return the next day, PPSWO may not be able to accommodate them if our schedule is full.

32. In addition to burdening our patients' ability to access abortion, the Challenged Requirements are harmful to patients' health. When some patients come to our clinic seeking

abortions, they are very ill and need an abortion as soon as possible. For example, some patients experiencing hyperemesis gravidarum (severe nausea and vomiting) are not able to go about their daily lives as long as they are pregnant because they are too ill. Patients may have other medical conditions necessitating an abortion, such as needing to start cancer treatment. I have said to patients many times, "Medically, I should be able to provide you with care now," but I am not able to do so because the state has inserted itself into the physician-patient relationship.

33. At a minimum, the Challenged Requirements force a patient to delay time-sensitive abortion care until later in their pregnancy without medical rationale. While abortion is extremely safe, its risks increase as pregnancy progresses.

34. The Challenged Requirements can be particularly devastating for patients who have received diagnoses of severe fetal conditions. These patients may have already spent weeks reviewing information with other providers, yet are still forced to delay their abortion further and prolong their grieving process.

35. The Challenged Requirements also impose psychological and emotional burdens on patients. Forcing a patient to remain pregnant longer, when they are sure they want to proceed with an abortion, is often distressing for a patient, particularly in cases of rape or incest. This is especially true since there is no medical benefit to the delay. It communicates to patients that there is something morally different about their treatment and that they should have a sense of shame about it, thereby stigmatizing them and making them feel alone. While abortion is a very common medical treatment, the Challenged Requirements send the opposite message—that there is something exceptional and bad about a patient's medical care.

36. The Challenged Requirements also impose psychological and emotional burdens on patients by requiring providers to provide the same information to all patients, regardless of

their individual circumstances. For example, we must inform patients of the estimated age of the embryo or fetus and whether there is detectable embryonic or fetal cardiac activity, even though some abortion patients may not want to hear this information or consider it relevant to their decision to have an abortion.

37. These laws also frequently push patients past the gestational limit for their preferred method of abortion. As discussed above, medication abortion is not available past the tenth week of pregnancy in Ohio. I can recall one day recently when four patients who had been eligible for medication abortion on their first visit to the clinic were no longer eligible for medication abortion by the time they were able to return for their second visit. This can be particularly harmful for patients for whom medication abortion would be safer due to a medical condition than a procedural abortion and for patients who are survivors of rape or incest who may fear re-traumatization by having an instrument placed in their vagina.

38. The Challenged Requirements also impose additional costs on patients because the abortion becomes more complex and thus more costly later in pregnancy.

39. In an effort to reduce these burdens on patients, PPSWO has recently started to have some patients complete their second visit for a medication abortion via telemedicine at least 24 hours following their in-person visit to the clinic. However, these patients must still schedule two separate appointments and wait at least 24 hours before undergoing an abortion without medical justification. Furthermore, virtual appointments are not feasible for many patients, such as those without privacy at home or those receiving procedural abortions. Accordingly, the vast majority of abortion patients must still make two separate appointments to our clinic for no legitimate medical reason.

40. Compliance with the Challenged Requirements also burdens PPSWO staff by requiring them to jump through medically unnecessary administrative and paperwork hoops. We have faced tremendous challenges seeing patients as soon as possible, particularly given the increased volume of patients visiting our clinics due to the total or near-total abortion bans that have been enacted in neighboring states since the Supreme Court's ruling in *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215 (2022). The Challenged Requirements pose an additional hurdle to our staff as they seek to provide safe and time-sensitive care to patients.

41. The Challenged Requirements do nothing to improve patient health, safety, or the informed consent process. Instead, they impose additional burdens on patients seeking to access time-sensitive abortion care and undermine patient health. As a health care provider, it is my duty to obtain informed consent from patients—I do not need the state to mandate this.

The undersigned hereby affirms that the statements made in the foregoing affidavit are true, under penalty of perjury.

DAVID AZAR
NOTARY PUBLIC
STATE OF OHIO
Comm. Expires
09-26-2027

Sharon Liner, M.D.
Planned Parenthood of Southwest Ohio

Sworn to and subscribed before me this 26 day of March, 2024.

Notary Public

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

PRETERM-CLEVELAND, et al., *Plaintiffs*, v. DAVE YOST, *et al.*, *Defendants.*	Case No. Judge

AFFIDAVIT OF AIMEE MAPLE IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Aimee Maple, being first duly sworn and cautioned according to law, hereby state that I am over the age of 18 years and am competent to testify as to the facts set forth below based on my personal knowledge:

1. I am the Director of Finance of Preterm-Cleveland ("Preterm"), a plaintiff in this case. Preterm is a nonprofit sexual and reproductive health clinic in Cleveland that offers abortion care and sexual health services.

2. I have held this position since 2022. Previously, I was Preterm's Finance Manager, and prior to that, from 2011 until 2014, I held the position of Patient Advocate at Preterm. Presently, as Director of Finance, I am responsible for the overall financial health of Preterm. My responsibilities also include providing financial counseling to patients and day-to-day running of the clinic. I supervise the clinic's intake staff and the work of the Patient Advocates. Approximately 5 times a month, I step in to act as a Patient Advocate.

3. Patient Advocates work at Preterm's appointment center, where we speak on the phone with patients to schedule appointments, and also meet in person with patients to provide

support and information, explain the medical care and treatments we provide, and provide extensive patient education, including pregnancy options counseling.

I. Preterm

4. Preterm provides procedural and medication abortions, birth control, STI testing and treatment, yearly gynecological exams, miscarriage management, and ultrasounds. Over 90% of our patients come to us for abortions.

5. Preterm provides medication abortion through 9 weeks, 6 days, as dated from the first day of a patient's last menstrual period ("LMP") and procedural abortion through 21 weeks, 6 days LMP.

6. Most of our patients live in Northeast Ohio, but we also have many patients from across the state, as well as from other states—mostly Georgia, Pennsylvania, Tennessee, Florida, and Texas. The majority of our patients are economically disadvantaged. The majority also qualify for Medicaid. 65% of our patients already have children.

II. The Challenged Requirements

7. I understand that Ohio law requires that, before Preterm can provide an abortion, the patient must meet in person with one of our physicians to receive certain state-mandated information, and that the abortion cannot be provided until at least 24 hours later.

8. I understand that Ohio law also requires that, at least 24 hours before providing an abortion, Preterm must perform an ultrasound to determine whether there is any embryonic or fetal cardiac activity and, if such cardiac activity is detected, give the patient a notice in writing that such activity was detected and the statistical probability of carrying the embryo or fetus to term based on gestational age, obtain the patient's acknowledgment of receipt of said information, and offer the patient a chance to hear or view the activity.

9. In my opinion, these requirements (together, the "Challenged Requirements") burden, discriminate against, and stigmatize our patients, risk harm to their health and well-being, and disrupt and undermine the relationship of trust between medical providers and patients, with no countervailing benefit to patient health or safety.

III. Patient Education and Informed Consent at Preterm

10. When a patient first calls Preterm, they reach a Patient Advocate at our appointment center who finds out when the patient wants to come in. Generally, an appointment can be made about a week following the call.

11. At an abortion patient's first visit to Preterm, they receive an ultrasound. Afterwards, the Patient Advocate meets with the patient for patient education, including pregnancy options counseling.

12. Options counseling is a discussion exploring, and making sure the patient understands, all of their options, which include terminating the pregnancy, continuing the pregnancy to term, and making a plan for parenting or for adoption.

13. The education session is an approximately 45-minute meeting conducted in a private office. It is typically one-on-one, but if the patient wishes a companion to join, they may do so, but only for part of the meeting, to be sure the patient is not being pressured or coerced and that their decision is their own.

14. During this meeting, the Patient Advocate provides the options counseling, discusses any patient interest in or desire for birth control options and aftercare, and provides a link to a state website that contains informational material. The meeting also includes some discussion of the cost of the abortion and whether the patient would like to be connected with resources that can provide financial assistance.

15. We always make sure that if a patient decides to have an abortion, they have understood the alternatives. If the Patient Advocate—or any other staff member—senses that a patient is unsure of what they want, we help them identify and consider what they are unsure about and make sure they take the space and time they need to come to the right decision for themselves. We also give the patient an "Ambivalence Workbook" that poses questions about their decision and helps them work through the answers.

16. If any patient remains uncertain after spending time with the Patient Advocate and working through the workbook, we advise them to take additional time with their decision and assure them that they can make another appointment if they later decide to move ahead with an abortion.

17. We also make sure that the decision to have an abortion is the patient's own choice. Patient Advocates are trained to assess whether the patient is at our clinic of their own accord, or whether someone has pressured them. When a patient first arrives at the clinic, the initial paperwork that they fill out asks them questions that include whose decision it was to come to the clinic, whether they feel safe in their relationships, and whether there are people in their life who are supportive. Later, at our education session, we listen and ask more questions. If we suspect coercion or pressure, we ask about it specifically. We will not provide an abortion for a patient if it is not their own voluntary decision to have one.

18. After this education session with the Patient Advocate, if the patient has decided to proceed with an abortion, they meet with a physician who has another discussion with the patient. The physician informs the patient of the nature and purpose of the abortion, as well as its risks, benefits and alternatives, allows them to ask questions, provides them with the state-mandated information, obtains their informed consent, and has them sign an informed consent form.

19. Nearly every patient is completely certain of their decision when they arrive for their first appointment.

20. Preterm ensures, and would ensure regardless of any state law, that in every case the patient is aware of the nature and purpose of the anticipated abortion care, as well as the risks, benefits, and all alternatives to abortion, that the patient has all the information they need to make an informed decision whether to proceed, and that any decision to have an abortion is fully informed and fully voluntary.

IV. Impact of the Challenged Requirements on Preterm and Preterm's Patients

21. Although, by law, the patient can return to the clinic to obtain an abortion 24 hours after they have received the state-mandated information that must be provided at their first appointment, there are many practical factors that determine how soon that second appointment can actually be scheduled.

22. To start, Preterm has to find an available appointment that matches the patient's needs. Very often, a patient's own schedule precludes the next available appointment. For example, many patients have work schedules that leave them free only on Saturdays. Likewise, many patients are only able to get child care on certain days, or need to take time, even up to several weeks, to gather the money necessary to make another trip back to the clinic.

23. Exacerbating this, patients often encounter other problems beyond their control that force them to re-schedule (e.g., car trouble, their child care falls through). Many times, in my experience, patients have had to reschedule twice or more.

24. For procedural abortions that require cervical ripening, patients must begin their appointment in the morning. Accordingly, if a patient is receiving a procedural abortion that requires cervical ripening, and comes in for their first visit in the afternoon, they typically cannot return until at least two days later, because 24 hours would not yet have elapsed between that first

appointment and the next available morning abortion appointment (i.e., on the morning of the following day).

25. Moreover, because Preterm is not open every day of the week, depending on when their first appointment takes place, a patient may have to wait an additional day or two to return.

26. In my experience, the second appointment is often at least a week after the first one, and sometimes even later.

27. It can be very painful for a patient to be forced to remain pregnant for longer than necessary when they are seeking to have an abortion. For example, some patients have such terrible nausea and vomiting that forcing them to remain pregnant against their will for another day or another week can be devastating to their health and well-being.

28. It can also be dangerous for a patient to have to continue a pregnancy that they desire to terminate. In January of this year, for example, I spoke with a patient with diabetic retinopathy who came in for an abortion. She explained to me that this disease requires regular injections into the eye to slow the progression of the disease from worsening vision to blindness. Because the medication can cause pregnancy loss or fetal anomalies, her eye doctor told her that he would not administer the treatment as long as she was pregnant, even though he knew she planned to obtain an abortion. The patient was, understandably, very worried about losing her vision. She was also worried because pregnancy makes diabetic retinopathy progress faster. We could not provide her abortion that day due to the 24-hour waiting period. We scheduled it as soon as we could after the 24 hours had elapsed, but the patient was still forced to wait longer than was necessary to obtain time-sensitive care.

29. It is also more emotionally painful for a patient to have to prolong a pregnancy that they have resolved they are going to end. In one sad, recent case, I met with a low-income patient

who was pregnant as the result of a rape. She had traveled to Preterm from another state. After her first appointment, she had to return home and could not come back until a week later because she could only get off from work on Saturdays. It was particularly traumatizing for this patient to wait an entire week for her abortion, as it meant having to continue for another week with a constant reminder of her rape.

30. During the time that a patient is forced to remain pregnant, if they are having an uncomfortable or incapacitating pregnancy, they may be unable to work or may be less able to take care of the children they already have. Being forced to remain pregnant against their will–and endure all of the side-effects and risks associated with pregnancy–can be particularly distressing and harmful for them.

31. Hundreds of times, when I have informed patients that they must leave and come back for a second appointment, they have begged me, "Please, please, just give me the abortion today." Their reasons have included (for example) that they will not be able to get additional child care, that they drove all the way here from as far away as Tennessee, or that they are in an abusive relationship and fear repercussions or abuse from their partner if the partner discovers that they are pregnant and/or seeking an abortion. In cases where a patient must hide a visit to the clinic from an abusive partner, it is much harder to hide two visits than one. People beg us for "an exception," but we have to tell them "no" because the Challenged Requirements only contain a narrow medical emergency exception. This happens at Preterm, on average, several times a day.

32. The cost of an abortion also increases as the pregnancy progresses. The cost of a procedural abortion goes up every two weeks of pregnancy, depending on the week of pregnancy. The later in pregnancy, the longer the procedure takes, and later stages require increasingly expensive medical supplies. This means that the delay created by the Ohio laws may not only end

up increasing a patient's overall financial burden but can also result in further delay (and even greater costs) if a patient needs additional time to raise the funds to pay for more expensive care.

33. People under economic stress – low-income patients, people who don't have access to a car, people whose jobs don't have paid time off or leave, or who have unpredictable/ inconsistent work schedules – suffer terribly from the Challenged Requirements. For some patients struggling with poverty, scrounging up the money for gas (or child care) for the second trip may mean dipping into or depleting already limited funds needed for food, rent, or utility bills for that month. Likewise, when a patient must travel to Preterm from far away, they may need to find funds to cover not only gas and child care, but also the cost of food and overnight lodging for the additional trip.

34. A few times a month, the delay caused by the Challenged Requirements pushes a patient past the point of 9 weeks and 6 days LMP. Because, due to Ohio law, Preterm is only able to provide medication abortion up to 70 days or 10 weeks LMP, a delay that pushes a patient past the 70-day point means that the patient is no longer eligible for a medication abortion and must have a procedural abortion instead. Some patients, for various reasons, prefer medication abortions. As examples: some find a medication abortion less invasive and more like a spontaneous miscarriage; a medication abortion can allow a patient to feel more in control of the process and more private because the abortion is completed at home; and if a patient has experienced sexual trauma, they may wish to avoid the insertion of instruments into the uterus.

35. Sometimes, the Challenged Requirements even push a patient past the date when they could have had an abortion here in Ohio. As a recent example, in February this year, a patient came in who was 21 weeks and 4 days LMP. Abortion at that stage is a 2-day procedure. She had come in on a Friday, and Preterm is closed on Sunday. Given that the legal limit for abortion in

Ohio is 22 weeks LMP, by Monday, it would have been too late for the patient to legally obtain an abortion in Ohio, so we had to tell her to try to schedule an appointment in Pennsylvania or Michigan.

36. Moreover, in some cases, for medical reasons, a patient may need to have another ultrasound at their second visit. For instance, if there has been bleeding between appointments, an ultrasound is necessary to determine whether the patient is still pregnant. In situations where no embryonic or fetal cardiac activity was detected at a patient's first visit, but it is detected for the first time at the second, the law requires that the patient leave and return again for another visit, after yet another 24 hours. This turns what could have been one visit into not only two, but three, visits, for no medical reason at all.

37. The Challenged Requirements are unnecessary to ensure that patients provide fully informed and voluntary consent to an abortion. Patients have numerous opportunities to consider and change their mind: before making the first appointment, before coming in for the appointment, and at any time during that appointment, including during patient education and the time they have to ask questions. As noted above, any patient who requires additional time to be certain of their decision is encouraged to take as much time as they need, and this would be true irrespective of any mandate under Ohio law.

38. The Challenged Requirements are also patronizing and insulting. For nearly all of our patients, by the time they call Preterm for an appointment, they have already considered their pregnancy options, understand the nature of abortion care, and have made up their mind that they want an abortion. They may have prayed, journaled, or spoken to family, friends, and/or clergy to reach their decision. Many of them already have children. They know what's right for themselves. They are experts on their own lives, and they know whether or not now is the right time for them

to continue a pregnancy. These requirements assume that our patients are ignorant and incapable of making this decision without the government telling them what information to consider, and how long to consider it. They also imply that our patients cannot be trusted to take sufficient time to make the decision unless the state forces them to do so.

39. In the patient education sessions following their ultrasound, patients often complain to the Patient Advocates about being informed that there was embryonic or fetal cardiac activity detected. Patients have expressed that they feel judged, stigmatized, or insulted by being told this information when they have already told us that they want to terminate their pregnancies. Informing patients who have already made up their minds about terminating their pregnancies that cardiac activity has been detected has no purpose other than to make patients feel stigmatized, upset, or shamed and judged for their decision.

40. The Challenged Requirements not only burden Preterm's patients, they burden and harm Preterm's staff. When patients beg us for "an exception" to the Requirements, or are violently nauseous or facing heightened medical risks or physical danger due to having to put off their abortion, it is excruciatingly difficult for our staff to have to send them away.

41. Having to enforce the Challenged Requirements also undermines the relationships that our staff members form with our patients. Our patients come to us, trusting that we will provide medical treatment that is in accord with their best interests, but instead we are forced to impose a non-medical requirement that prevents us from doing what is best for our patients.

The undersigned hereby affirms that the statements made in the foregoing affidavit are true, under penalty of perjury.

aimee l maple
Aimee Maple

Sworn to and subscribed before me this 27 day of March, 2024 in Cleveland, Ohio.

Alexis Mangan
Notary Public

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

PRETERM-CLEVELAND, *et al.*, *Plaintiffs*, v. DAVE YOST, *et al.*, *Defendants.*	Case No. Judge

AFFIDAVIT OF DR. DAVID BURKONS IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Dr. David Burkons, having been duly sworn and cautioned according to law, hereby state that I am over the age of 18 years and am competent to testify as to the facts set forth below based on my personal knowledge:

1. The facts I state here are based on my experience, information obtained in the course of my duties at the Northeast Ohio Women's Center ("NEOWC"), and personal knowledge that I have acquired through my role at NEOWC.

2. I submit this affidavit in support of Plaintiffs' motion for a preliminary injunction against Ohio Revised Code Sections 2317.56 and 2919.192-194, as specified in the Complaint in this action.

3. I am a board-certified obstetrician-gynecologist. I received my M.D. degree from the University of Michigan in 1973.

4. I am licensed to practice medicine in the state of Ohio. In 2014, I founded NEOWC, where I serve as Medical Director. Prior to starting NEOWC, I was in private practice with University Hospitals in Cleveland, and I also served as Medical Director of Preterm-Cleveland for approximately ten years.

5. As NEOWC's Medical Director, I supervise physicians and clinicians and provide reproductive health care to patients. I also oversee the provision of all abortion services at NEOWC, and I am responsible for developing and approving NEOWC's policies and procedures. I also oversee and supervise NEOWC's compliance with all applicable laws and regulations, including those that are being challenged in this lawsuit. In addition, I personally provide both medication and procedural abortions at NEOWC.

I. Northeast Ohio Women's Center

6. NEOWC operates an ambulatory surgical facility ("ASF") located in Cuyahoga Falls, Ohio (near Akron), which offers both procedural and medication abortion, as well as a medication-only abortion clinic in Shaker Heights, Ohio (near Cleveland), and another medication-only abortion clinic in Toledo, Ohio (Toledo Women's Center).

7. NEOWC generally provides abortions up to 17 weeks in pregnancy, as dated from the first day of a patient's last menstrual period ("LMP"). NEOWC provides medication abortions up to nine weeks, six days LMP (i.e., the second medication must be taken by nine weeks, six days LMP). For any patient seeking an abortion past that point, we gauge on a case-by-case basis whether we are able to provide care at their stage of pregnancy, up to the legal limit for abortion in Ohio.

8. The majority of NEOWC's patient population resides in Ohio, but that is by no means exclusively the case. At Toledo Women's Center, we see a number of patients from Michigan. More recently, we have seen increasing numbers of patients traveling from Indiana or Kentucky in search of abortion care at our various clinics.

9. Approximately two-thirds of our patients are receiving some sort of public financial assistance in their personal lives. Because Ohio law precludes Medicaid from covering abortion care, many of these patients rely either on private financial support, such as that available through

donor organizations, or attempt to amass the funds for their abortion care on their own. We also see a large number of patients who are in vulnerable domestic situations, such as abusive relationships.

10. Our patients seek abortions for any number of reasons, depending on their own personal, financial, medical, or other circumstances. For example, some are already parents and, after careful consideration, have decided that expanding their family is not in their or their family's best interest at that time. Many are in difficult financial circumstances and are straining to provide for their existing children. Other patients are young and feel that they are not ready to become parents or are pursuing work or school opportunities. Some have health conditions such as heart disease, hypertension, diabetes, or lupus that may be substantially complicated by pregnancy. Some patients are in abusive relationships or are pregnant as a result of rape or sexual assault and are concerned that carrying the pregnancy to term will tether them to the person abusing them.

II. The Challenged Requirements

11. I am generally familiar with the requirements set by Ohio Revised Code sections 2317.56 and 2919.192–194 because NEOWC is required to comply with them. These laws impose a series of medically unnecessary—and in many instances, medically harmful—requirements that burden, interfere with, penalize, sometimes prevent, and discriminate against, our patients who are seeking abortion care, as well as our staff who wish to assist them in doing so.

12. I understand that the challenged laws require that a physician meet with a patient in person at least 24 hours before an abortion to provide the patient with certain state-mandated information and allow them to ask questions. I understand that these laws also require that, prior to providing an abortion, a provider first determine whether there is detectable fetal or embryonic cardiac activity and, if such activity is detected, provide the patient with that information and

additional state-mandated information at least 24 hours before providing an abortion. I understand that violation of these requirements may carry criminal, civil, and/or disciplinary penalties.

III. Abortion Safety and Informed Consent

13. Abortion, whether medication or procedural, is very safe, straightforward, and effective. The risks are extremely low, and it is far safer than carrying a pregnancy to term, especially for patients who have medical problems that may be exacerbated by pregnancy. The risk of death from childbirth is more than 12 times higher than the risk of death from abortion.

14. As a physician and medical director of NEOWC, I am familiar with the requirements of informed consent, including those imposed by Ohio law. Under principles of informed consent, anyone who is going to have any kind of medical treatment should know what the treatment is; why it is being suggested; what the risks involved are, however minimal; the anticipated benefits of the proposed treatment; and what alternatives they may have to that particular medical treatment. At NEOWC, we take this responsibility very seriously. The patient must be given as much time as they want or need to consider the treatment, ask questions, get a second opinion, or seek whatever other information they may need. Under Ohio law and standard medical practice, these requirements can be waived only in emergency situations.

15. Even in the absence of the challenged laws, NEOWC would certainly obtain informed consent before any abortion, which would be our continuing obligation as medical professionals. The challenged laws do not help to fulfill that obligation, and at times interfere with it.

16. Throughout the process at NEOWC, there are numerous opportunities for patients to ask questions or obtain further information about abortion and about other pregnancy options before consenting to and being provided with an abortion. Initially, the patient must contact our office to schedule an appointment, and our schedulers—like all of our staff—are equipped to

answer basic questions about abortion. Our website also has information about both procedural and medication abortion. Upon receiving an ultrasound, the patient has an opportunity to speak with the ultrasonographers. Ultrasonographers at NEOWC, many of whom also serve as educators, are also able to answer patient questions, and frequently do so. Our educators also engage in detailed discussion with the patient to ensure their decision is voluntary, and to ensure that their questions and concerns have been addressed. The patient will also speak one-on-one in a private setting with the physician who will provide the abortion. At each of these points, our staff ensures that the patient is confident in the decision to proceed before consent is obtained and an abortion is provided.

17. While we always work to ensure that each patient's decision is fully informed, it is also the case that the overwhelming majority of our patients come to us with their minds made up to proceed with an abortion. In the exceedingly rare case that we perceive that a patient is uncertain about proceeding with an abortion, we make sure they have all the facts and all the time they need to make their decision, and we don't proceed unless the patient is sure. If we perceive that the patient is making a decision based on inaccurate information, we provide them with the correct information. We are also careful to look out for any indication that the patient is being coerced into having an abortion, and we always inquire and take any additional steps necessary to ensure that such coercion is not present.

18. Although rare, in the event we sense a patient is uncertain or ambivalent about proceeding, we will offer to postpone the abortion and/or tell the patient they can call to reschedule once they have made up their mind.

19. As part of our counseling process at NEOWC, patients receive information about alternatives to abortion. NEOWC would provide this information to our patients even absent any

statutory requirement as part of standard medical informed consent. Moreover, in addition to routine options counseling, our physicians and clinic staff provide further information to answer any patient questions. We also have patient educators who are trained to talk with patients about options other than abortion, and who can refer patients to adoption agencies for more information.

IV. The Challenged Requirements Do Not Serve the Purposes of Informed Consent

20. The purpose of informed consent is to ensure a patient's autonomy is respected. Rather than serving that interest, the Challenged Requirements undermine it by forcing competent people who have decided to obtain medical care to delay that care unnecessarily, imposing risks to their health and wellbeing.

21. In my experience, patients almost always want to proceed with an abortion on the day they first come to NEOWC. When we inform them of the mandatory 24-hour waiting period, they routinely become angry and frustrated. The logistics of simply getting to us for an appointment are often considerable for them: travel, taking time off work, child care, and lodging, to name a few. The last thing they want to hear is that they have to delay their care for a full day, if not longer, and come back to the clinic a second time.[1] Sometimes that frustration is initially directed at us and, even when we explain that it is the result of a state legal requirement, patients often remain frustrated at the unnecessary delay. Even if they don't blame us, certainly the situation does not help us create a supportive environment for our patients, because the waiting period makes patients feel like their judgment is not being trusted and respected.

[1] While some medication abortion patients do not need to return to the clinic again and can instead take home with them a lockbox containing the medications, which opens with a code after 24 hours has elapsed, this option is not available to any of our procedural abortion patients, and it does not eliminate 24-hour delay in accessing care.

22. The in-person and 24-hour waiting period requirements do nothing to support patient autonomy. Our patients have already made an appointment and sought us out and, once they arrive at the clinic, we always ensure that they are fully informed about the procedure. Forcing them to delay the procedure and, in many cases, return to the clinic again does nothing to help ensure informed consent.

23. These requirements are also very frustrating for me and for other clinic staff. Our goal is to effectuate our patients' wishes and ensure they get the best care possible—indeed, that is my duty as a physician. Forcing us to unnecessarily delay providing our patients with time-sensitive care does nothing but inhibit our efforts to do so.

24. I am unaware of any other time-sensitive medical procedure that requires either a separate, in-person visit for informed consent or a 24-hour waiting period. A person could consent to a much more intrusive and high-risk procedure on the day of the procedure, by signing a consent form with non-physician staff mere minutes before the procedure begins. For example, earlier in my career, I routinely obtained patient consent for a tubal ligation—which is a considerably more significant procedure than abortion, with much greater risks—shortly before the procedure was performed.

25. There is no medical justification for the Challenged Requirements' 24-hour waiting period, or the requirement of in-person informed consent with a physician.

26. Moreover, the information that the state mandates we provide, including, e.g., the existence of detectable embryonic or fetal cardiac activity, is not at all relevant to a patient's informed consent, and may in some cases only serve to upset or distress a patient who has already thought long and hard about the very personal decision to have an abortion.

V. The Challenged Requirements Impose Considerable Burdens

27. The Challenged Requirements impose significant, and completely unnecessary, burdens on NEOWC patients and staff.

28. For many patients, simply traveling to the clinic is already a financial and logistical burden. They may have to take a day off work, arrange or pay for a ride, or arrange for child care. As noted above, while some medication abortion patients are able to do their second visit via telemedicine, most patients have to make two trips to the clinic. They are therefore forced to endure these burdens twice, and/or arrange for lodging near the clinic, especially if they have traveled a long distance to reach our clinic.

29. The majority of our patients are already in a stressed financial situation and the burdens created by the challenged laws fall most heavily on those patients. Many of them are very upset about it; some tell us that if they miss more work, they will be fired. For those who don't have the ability to take paid time off, missing another day's wages is much more significant to them than to those with greater means.

30. These burdens also fall heavily on patients from rural areas. The most socioeconomically disadvantaged region of Ohio is the southeastern Appalachian area, which is at least two hours from any clinic. For many patients who come to NEOWC from that area of the state and for whom a second appointment by telemedicine is not an option, the 24-hour waiting period may force them to make two long trips. There is no public transportation that can bring them to us. A single day trip is already hard enough for them to arrange both logistically and financially, let alone two.

31. It is also critical to note that these requirements often result in a longer delay than 24 hours. Patients might not be able to arrange a ride or take another day off of work in order to return 24 hours after their first appointment. Alternatively, if a patient arrives for their first visit

later in the day, the 24-hour waiting period would not elapse until late the following day. If there are no late afternoon appointments available the following day, that means that they will be unable to get an abortion on the following day even if they stay overnight. In some cases, it can be weeks before a patient is able to return after the first visit due to overlapping, compounding challenges.

32. Although abortion is a very safe procedure, the minimal risks associated with it do increase as a pregnancy progresses. As a general rule, the earlier the procedure is done, the more minimal the risks are to the patient.

33. Probably once or twice a week, we encounter a patient at NEOWC who is approaching the 10 week LMP cut-off for a medication abortion, which is a limit imposed by Ohio law despite the fact that medication abortion can be safely provided to 11 weeks LMP. Because of the 24-hour delay, and the further delays that might ensue, people in that situation sometimes have to have a procedural abortion when they would prefer medication instead. Some patients prefer medication abortion because it feels less invasive and more natural than procedural abortion and because completing the process at home allows for more privacy and control. Others may have a medical contraindication for procedural abortion, making medication abortion safer for them.

34. For example, recently I saw a patient who was 7 weeks and 4 days LMP at the time of her first visit. Because of the requirements imposed by the challenged laws, she had to make a second appointment to come back, but she was unable to keep that appointment because of changes in her work schedule. By the time she was able to come back, she was past the state-imposed limit for medication abortion, which meant she had to have a procedural abortion despite her stated preference for medication abortion. Without the waiting period, she could have had an abortion by her preferred method, weeks prior. She repeatedly expressed frustration with the delay that the law imposed, which barred her from being able to choose her abortion method.

35. Forced delay also inflicts emotional harm on patients. For some patients, the decision to have an abortion is a difficult one and once they have made it, they want to proceed promptly. This is especially true for survivors of rape or incest, or patients with a wanted pregnancy where a fetal diagnosis or medical complication has led the patient to choose abortion. Forcing these patients to remain pregnant against their will can be particularly harmful and distressing.

36. Being forced to continue being pregnant for a longer period of time also imposes additional stress on the body and may force the patient to endure related symptoms for longer than necessary. For example, the majority of NEOWC's patients are at a relatively early stage of pregnancy. A significant number of them suffer from hyperemesis gravidarum (severe morning sickness), which causes horrible nausea, vomiting, and dehydration. After an abortion, their symptoms clear up extremely quickly. If they are forced to delay, they are forced to endure these symptoms for longer.

37. We see a significant number of patients who are in extremely difficult or even dangerous domestic situations, including many who suffer from intimate partner violence ("IPV"). Some who are in abusive relationships feel that until they are no longer pregnant, they have to stay with their abusive partner for financial support. In essence, the delay prevents them from removing themselves from their abusive relationship and moving on with their lives. In addition, many of our patients are trying to keep their abortion confidential, sometimes because of the prospect of retaliation from a domestic partner. If they have to delay desired care and make a second trip, they will have a more difficult time preserving that confidentiality. For those who are in a difficult or violent domestic situation, loss of their privacy could have potentially dangerous consequences, and time is of the essence in obtaining abortion care.

38. I deal with thousands of patients every year. It just is not my experience that these laws cause patients to rethink their decision once they have made it.

39. Presenting the patient with irrelevant information, including information about the presence of embryonic or fetal cardiac activity, is also a requirement that serves no medically beneficial purpose. It does not help patients arrive at a decision, but it may upset those who are terminating wanted pregnancies because of fetal diagnoses or medical complications. Patients receive no medical benefit from being informed of embryonic or fetal cardiac activity because it is medically irrelevant information. Based on my experience treating patients, this requirement seems to exist for no other reason than to try to prevent people from getting abortions by attempting to shame them or make the process more difficult.

40. The Challenged Requirements stand at odds with best medical practices, with the patients' interests, and with my ethical duty and desire to serve my patients as best I can. As medical providers, we necessarily have to ensure that a patient's decision is fully informed and voluntary, and that they consent to any medical treatment. That is standard medical practice and something that we would do absent any law. All that the 24-hour waiting period requirement does is strip away autonomy from patients who have already made the decision about their medical treatment, stigmatize them for their decision, disrupt the doctor-patient relationship of trust, and delay and burden patients' receipt of time-sensitive care, at risk to their physical, mental, and financial health and well-being.

The undersigned hereby affirms that the statements made in the foregoing affidavit are true, under penalty of perjury.

Dr. David Burkons

Sworn to and subscribed before me this 27TH day of March, 2024.

Notary Public

TIFFANY ANN CARDENAS
NOTARY PUBLIC, STATE OF OHIO
My Commission Expires 11/15/2025

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Affidavit of Dr Haskell.pdf

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E-Signature Summary

E-Signature 1: Martin Haskell (MH)
March 27, 2024 11:09:30 -5:00 [5BFA813C9B86] [174.48.65.150]
martyh@fortemgt.com (Principal) (Personally Known)

E-Signature Notary: Theresa M Sabo (TMS)
March 27, 2024 11:09:30 -5:00 [E9CEFC8FBA4C] [65.60.211.87]
tess.sabo@gmail.com
I, Theresa M Sabo, did witness the participants named above electronically sign this document.

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

PRETERM-CLEVELAND, *et al.*, *Plaintiffs*, v. DAVID YOST, *et al.*, *Defendants.*	Case No. Judge

AFFIDAVIT OF W.M. MARTIN HASKELL, M.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, W.M. Martin Haskell, M.D., having been duly sworn and cautioned according to law, hereby state that I am over the age of 18 years and am competent to testify as to the facts set forth below based on my personal knowledge:

1. I am the sole shareholder and Medical Director of Women's Med Group Professional Corporation ("WMGPC"), which has owned and operated Women's Med Center Dayton ("WMCD") in Kettering, Ohio since 1983. WMGPC was formerly Women's Medical Professional Corporation. WMGPC and its predecessor organizations have provided safe and compassionate reproductive health care in Ohio since 1973.

2. I am a physician with nearly 50 years' experience in women's health. I have been a licensed physician in the state of Ohio since 1974.

3. I earned a Bachelor of Arts from Ohio Wesleyan University in 1968 and a Doctorate of Medicine from the University of Alabama in 1972. I completed five and one-half years of postgraduate residency training in anesthesia, general surgery, and family practice. I passed my Board exam in family medicine in 1978. I also personally provided abortion care in an outpatient setting from 1978 until 2019.

4. As owner of WMGPC, I supervise and manage the provision of all abortion care at WMGPC facilities and am responsible for developing and approving WMGPC's policies and procedures. I have also served as the Medical Director of WMCD since 1983. As Medical Director of WMCD, I supervise physicians and clinicians and oversee the clinic's daily operations, business matters, and compliance with all applicable laws and regulations.

5. I submit this affidavit in support of Plaintiffs' Motion for a Preliminary Injunction to block the enforcement of Ohio Revised Code Sections 2317.56 and 2919.192–2919.194 (collectively "the Challenged Requirements"). It is my understanding that these laws require that certain state-mandated information be provided by a physician in person to all patients seeking abortion, at least 24 hours before the patient obtains their desired abortion. As detailed further below, the Challenged Requirements burden both our patient population and WMCD staff by forcing patients to wait at least 24 hours to obtain abortion care that they have already decided they want; requiring patients to make a second trip to the clinic; and forcing them to receive certain state-mandated information that is not only unrelated and unnecessary to informed consent but potentially distressing, stigmatizing and/or misleading. The Challenged Requirements also interfere with both access to and the provision of vital abortion care, risking harm to patient health and well-being. Furthermore, the Challenged Requirements discriminate against patients who seek such care as well as providers who endeavor to provide such care.

6. The facts I state here are based on my experience, information obtained in the course of my duties at WMCD, and personal knowledge that I have acquired through my service at WMCD. If called and sworn as a witness, I could and would testify competently thereto.

I. Abortion Care at WMCD

7. WMCD provides an array of reproductive health care, including pregnancy testing, birth control, and abortion care. WMCD is an ambulatory surgical facility ("ASF") under Ohio

law. WMCD is the only abortion provider in the Dayton, Ohio area, and one of only nine clinics providing abortion care in the state.

8. Patients seeking an abortion in Ohio have a limited opportunity to obtain such care. Although a full-term pregnancy typically lasts 40 weeks, as measured from the first day of a patient's last menstrual period ("LMP"), Ohio prohibits abortion after 22 weeks LMP. WMCD provides procedural abortion through 21 weeks, 6 days LMP as well as medication abortion up to 70 days (10 weeks) LMP, the current legal limit for medication abortion under Ohio law.

9. WMCD serves a diverse patient population. Approximately 50 percent of our patients are poor or low income and receive some sort of funding assistance to pay for abortion care at WMCD. Our patients seek abortion for a wide variety of deeply personal reasons. For example, some patients seek abortion because they have concluded that they are unable to become a parent for the first time or add another child to their family due to their age, education or work responsibilities, existing caretaking obligations, or a lack of financial resources or emotional support. Some patients do not want to become parents at all. Some patients make the decision to terminate their wanted pregnancy because of pregnancy complications that endanger their health or life or because of a diagnosis of a fetal anomaly. Other patients decide to have an abortion because they are experiencing intimate partner violence ("IPV") and feel that they do not want to be bound to their abusive partner or bring a child into an unsafe environment. There are also patients who seek abortion care because their pregnancy is the result of rape or incest.

II. The Challenged Requirements

10. I am familiar with the Challenged Requirements because I have complied with them in my practice and ensure that the physicians, clinicians, and other staff that I supervise at WMCD comply with them as well.

11. I understand that the State-Mandated Delay Requirements require that a physician meet with a patient in person at least 24 hours before an abortion to provide the patient with certain state-mandated information and allow them to ask questions. I understand that these laws also require that, prior to providing an abortion, a provider first determine whether there is detectable fetal or embryonic cardiac activity. If such activity is detected, the patient must be provided with the option to view or hear the cardiac activity and—at least 24 hours before an abortion can take place—be provided with additional state-mandated information. I understand that violation of these requirements may carry criminal, civil, and/or disciplinary penalties.

12. I believe the Challenged Requirements are medically unnecessary, redundant, and oftentimes cruel in practice. They burden and interfere with our patients' access to time-sensitive care, risking harm to their health and well-being; discriminate against and stigmatize our patients; and obstruct our staff's ability to exercise their best medical judgment in tailoring care to the needs of each patient. The Challenged Requirements also needlessly question our patients' thoughtful decision-making and undermine their ability to exercise their autonomy in seeking medical care.

III. Informed Consent and the Mandatory Waiting Period

13. Informed consent has always been a cornerstone of the practice of medicine. Its purpose is to explain the contemplated procedure or treatment to the patient and advise them of the risks, benefits, and alternatives thereto. The standard of care for any type of medical treatment inherently requires informed consent.

14. At WMCD, we take our obligations as health care providers very seriously and ensure that every patient understands and consents to their treatment. We would obtain informed consent for each of our patients regardless of whether there was a statutory obligation to do so because it is part of the ethical practice of medicine.

15. For patients seeking abortion, we always take the time to make sure that their decision is voluntary and fully informed. This has always been our practice, even before the Challenged Restrictions, and it would continue to be our practice even absent any statutory obligation. Our trained staff, including nurses, educators, and physicians, provide extensive information to all patients as well as an opportunity to ask any questions or share any concerns throughout the process. Nursing staff meet with each patient at the beginning of their first visit to inquire about their medical history, check their vitals, and perform an ultrasound along with any additional testing. Patients then meet with a patient educator who explains the intended abortion care to the patient, including any potential side effects and risks, and offers an opportunity to ask questions. For patients who want additional information, we provide online and telephonic resources. Lastly, patients meet with a physician who answers any additional questions, provides the state-mandated information to the patient, and ensures the patient completes the state-mandated forms. For patients who do not speak English, we use a telephonic translation service to translate each step of this process for them or schedule them for a day where a staff member who speaks their language is working. Throughout this process, patients have at least two or three one-on-one meetings with staff during which they can ask questions or share any concerns.

16. Our staff is trained to notice signs of patient hesitancy or uncertainty. If a patient exhibits such signs, a staff member will question whether the patient is certain that they would like to proceed with the abortion and talk with them about any concerns. We pride ourselves on creating a calm environment that allows patients the space to slow down and consider all their options before deciding to obtain an abortion. Staff also ensure that patients do not feel rushed about their decision to have an abortion. For example, if a patient is accompanied by a friend or family member, we ask the patient whether they would like the opportunity to return to the waiting room

to speak with that person about the information they have received and their options before proceeding. We also offer patients the opportunity to reschedule their appointment if they are unsure about proceeding with the abortion on the day it is scheduled.

17. Staff members are also trained to detect signs of coercion, such as whether the person who has accompanied the patient to the appointment is speaking on behalf of the patient or acting as their interpreter. If staff detects any signs of potential coercion, we make sure that a patient educator has time alone with the patient to enable them to speak freely or ask any questions in private, and take any other necessary steps to ensure the patient is safe and that any decision to have an abortion is knowing and voluntary. For patients who disclose IPV, we take care to ensure that their decision is knowing and voluntary and offer additional resources, including information on shelters.

18. Nevertheless, nearly all the patients we see are certain that they want to have an abortion when they walk through our doors. They are so sure that they often express anger or frustration at having to wait at least another 24 hours, if not longer, before being able to obtain medical treatment that they have already carefully considered and firmly decided that they want.

19. The Challenged Requirements paternalistically call into question a patient's decision about their pregnancy and undermine their ability to exercise their autonomy. The Challenged Requirements also stigmatize and embarrass patients who have already decided to terminate their pregnancies. These Requirements suggest an outright mistrust of patients' ability to make their own decisions and exercise their agency. They essentially say to every patient seeking an abortion, "We don't trust that you've made the right decision, so we are forcing you to think about this some more," without knowing anything about the patient or their circumstances.

20. Abortion is time-sensitive because there is a limited window in which patients can obtain care in Ohio, and the risks associated with abortion, although always minimal, do increase incrementally as a pregnancy progresses. I am not aware of any other similarly time-sensitive medical treatments or procedures that are subject to a statutorily imposed waiting period for informed consent. Moreover, I am not aware of any other medical procedure that is subject to a requirement of a separate, in-person visit for informed consent.

21. Informed consent is already an integral part of the standard of care and already legally required for all other medical care in Ohio without any waiting period. Thus, the Challenged Requirements are unnecessary and only serve to single out abortion patients and providers for discriminatory treatment, constrain best medical practice, undermine the doctor-patient relationship, and unnecessarily delay our patients' access to time-sensitive care.

IV. Impact of the Challenged Requirements on Patients and Staff

22. The Challenged Requirements impose immense burdens on our patients by creating senseless logistical obstacles to obtaining care without doing anything to improve patient health or safety. The Challenged Requirements necessarily force patients to delay their care by at least 24 hours, if not longer, and also subject them to a number of burdens and impediments discussed below, including having to make at least two trips to the clinic. For some of our patients, it can be incredibly difficult to make two trips to our clinic. For other patients, this obstacle may be insurmountable.

23. We have patients who travel to our clinic for abortion care from both distant parts of Ohio and from other states such as Alabama, Tennessee, and Texas. For those patients, two clinic visits means either an overnight stay near the clinic or two separate trips to the clinic. An overnight stay necessitates arranging and paying for overnight accommodations and potentially child care, and often results in lost wages from missed work. Two separate trips to the clinic require

two separate arrangements and costs for travel, in addition to any costs for child care and lost wages. These costs are substantial for patients living paycheck to paycheck and can mean the difference between being able to afford to put food on the table, or pay utility bills, and not. Even for patients who live near to the clinic, they may still have to take additional time off from work (and forgo another day's wages), explain their absence to others twice, and/or arrange additional child care if they already have children. In sum, no matter where patients live, the Challenged Requirements needlessly disrupt their lives.

24. For patients experiencing IPV or familial coercion, the Challenged Requirements are not only disruptive but dangerous. I have had patients who became pregnant by an abusive partner and wanted to terminate the pregnancy but were forced to find a way to conceal not one but multiple clinic visits to prevent their partner from finding out, risking retaliation. I have also had patients who needed to conceal their clinic visits from coercive family members. For these patients, an additional, unnecessary visit to the clinic increases the risk that their privacy will be compromised and that their personal medical decision will be revealed to those who could cause them harm.

25. The delay between a patient's first appointment and second appointment can become even more drawn out and burdensome due to clinic or patient scheduling constraints. We always try to schedule patients for their second appointment as soon as possible following the mandated 24-hour delay. However, we are often unable to schedule them for their second visit until several days or even weeks after their first visit given both clinic availability and the patients' own schedules, which may be complicated by work, school, and/or child care obligations, as well as obstacles related to securing transportation or funds for their care.

26. Additionally, for some patients, two trips can turn into three trips. This may be the case if the patient is pushed to a point in their pregnancy where they need a two-day (as opposed to one-day) procedure, or if embryonic or fetal cardiac activity is not detected during the patient's initial ultrasound, then cardiac activity is detected for the first time during the second visit, thereby requiring the patient to wait at least another 24 hours before obtaining their abortion.

27. The 24-hour delay is not only burdensome and disruptive to patients' lives, but also harmful to their health and well-being because it requires them to remain pregnant longer than necessary. Pregnancy inherently places a pregnant person's body under immense physiological stress because their organs—most notably the heart and kidney—are working overtime to compensate for the many biological changes taking place. Moreover, as the pregnancy progresses, the risk of experiencing a pregnancy-related complication, like preeclampsia, also increases.

28. Similarly, while abortion is always very safe, the risks associated with abortion do increase as pregnancy progresses. This means that forcing a patient to delay desired abortion care may unnecessarily subject them to a greater degree of medical risk when they eventually receive that care. Moreover, for patients who have chosen a particular method of abortion—such as medication abortion—for personal reasons (such as the desire to have a private abortion experience in the comfort of their home), forcing them to delay care risks pushing them past the point of being able to obtain their abortion through their preferred method. And for patients who are pregnant as a result of rape or incest, being forced to remain pregnant against their will for longer only further compounds the trauma they have already experienced and threatens their well-being. In sum, forcing patients to continue to remain pregnant—even though they have already decided to have an abortion—subjects them to an unnecessary risk of harm to their health and physical and mental well-being.

29. Additionally, because the cost of abortion generally increases as the pregnancy progresses, patients' financial constraints are further exacerbated by the delay. For some patients, the extra cost in turn creates yet more delay because they need time to collect the additional money for their care. The increased cost also makes it harder for patients to maintain privacy if they need to borrow money from friends or family.

30. The Challenged Requirements can also burden a patient emotionally. In medical practice, informed consent is typically tailored to the needs and circumstances of each patient because every patient is distinct. However, because of the Challenged Requirements, we are required to provide the same information to every patient regardless of their personal circumstances, and regardless of whether, in our medical opinion, providing certain information to a patient could cause them undue distress or harm.

31. For many patients, being forced to listen to a doctor explain the gestational age of their embryo or fetus and the chances of bringing the pregnancy to term, and being informed of the existence of embryonic or fetal cardiac activity and given an opportunity to view or listen to it, makes patients feel like they are being shamed for their carefully considered decision to have an abortion rather than supported by their health care provider, as they should be. This can be especially traumatic and hurtful for patients who are terminating a wanted pregnancy because of a fetal diagnosis or pregnancy complication, as well as for patients who are terminating their pregnancy because it is the result of rape or incest. We see patients' emotional responses most vividly in those circumstances. Forcing patients to listen to this information is especially cruel because it is entirely unnecessary to obtain their informed consent for an abortion in accordance with medical ethics and best medical practice.

32. The Challenged Requirements impose needless obligations on health care providers and restrict our ability to consider the circumstances of each patient and provide compassionate care in accordance with our best medical judgment. It is not our role as physicians to judge our patients or the choices they make for their own health. It is our role to assist patients who are seeking care that is within our scope of practice.

33. It is an affront to patient autonomy and contrary to medical ethics to be forced to provide patients with unnecessary information that may distress or harm them, and to tell patients that they must unnecessarily delay receiving time-sensitive medical care they have decided on. Indeed, the Challenged Requirements undermine both the patient-physician relationship and medical ethics by making patients feel like their decisions are not respected or trusted and by imposing a one-size-fits-all approach on the practice of medicine.

34. Compliance with the Challenged Requirements is also deeply upsetting for WMCD staff. On a daily basis, our staff is obligated to inform patients that they must wait at least 24 additional hours before they can obtain their abortion. Staff members are also forced—against their best medical judgment—to provide potentially distressing and unnecessary information to patients about pregnancies that they have decided to terminate. Staff bear the brunt of patients' emotional responses to the Challenged Requirements. This takes a heavy emotional toll on our staff and contributes to burnout.

35. Ultimately, the Challenged Requirements do not improve informed consent for abortion care or better ensure that a patient's decision to obtain an abortion is fully informed. Rather, the Challenged Requirements undermine the patient-physician relationship and force medical providers to act contrary to medical ethics and their best medical judgment. The Challenged Requirements also deny patients their autonomy and significantly interfere with and

burden their ability to timely access vital reproductive health care, risking harm to their physical and mental health and well-being.

The undersigned hereby affirms that the statements made in the foregoing affidavit are true, under penalty of perjury.

Martin Haskell
Signed on 2024/03/27 11:09:30 -5:00

W.M. Martin Haskell, M.D.

03/27/2024

Sworn to and subscribed before me this _____ day of March, 2024 in Franklin County, Ohio.

Signed on 2024/03/27 11:09:30 -5:00

Notary Public

NOTARY PUBLIC
STATE OF OHIO

Theresa M Sabo
Commission # 2016-RE-619622
Electronic Notary Public
State of Ohio
My Comm Exp. Nov 28, 2026

Notary Stamp 2024/03/27 08:09:30 PST E8CEFC8FBA4C

Notarial act performed by audio-visual communication

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

PRETERM-CLEVELAND, *et al.*, *Plaintiffs*, v. DAVE YOST, *et al.*, *Defendants.*	Case No. Judge

AFFIDAVIT OF DR. ADARSH E. KRISHEN IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Dr. Adarsh E. Krishen, having been duly sworn and cautioned according to law, hereby state that I am over the age of 18 years and am competent to testify as to the facts set forth below based on my personal knowledge:

1. I am a board-certified family physician with over 30 years of experience in family medicine. I am licensed to practice medicine in the state of Ohio. I have also been a Clinical Professor of Family and Community Medicine at Northeast Ohio Medical University in Rootstown, Ohio, since 2013. Since 2017, I have been the Chief Medical Officer of Planned Parenthood of Greater Ohio ("PPGOH"), a Plaintiff in this case. As PPGOH's Chief Medical Officer, I am familiar with the impact that R.C. 2317.56 and R.C. 2919.192–194 (collectively "the Challenged Requirements") have had on our operations, our staff, and our patients.

2. In my role as Chief Medical Officer of PPGOH, I supervise physicians and other clinicians, manage the provision of all medical services at PPGOH, and am responsible for developing PPGOH's policies and procedures. I currently spend the majority of my time at PPGOH fulfilling my supervisory and administrative duties. I also provide direct patient care, including medication abortion.

3. The facts I state here are based on my experience, my review of PPGOH's business records, information obtained in the course of my duties at PPGOH, and personal knowledge that I have acquired through my service at PPGOH. If called and sworn as a witness, I could and would testify competently thereto.

4. I submit this affidavit in support of Plaintiffs' Motion for a Preliminary Injunction to block enforcement of the Challenged Requirements. I am familiar with the challenged sections of Ohio law and their mandates. As PPGOH's Chief Medical Officer, I am also aware of their impacts on PPGOH's operations, patients, and staff.

5. I understand that the Challenged Requirements require that a physician meet with a patient in person at least 24 hours before an abortion to provide the patient with certain state-mandated information and allow them to ask questions. I understand that these laws also require that, prior to providing an abortion, a provider must first determine whether there is detectable fetal or embryonic cardiac activity. If such activity is detected, the patient must be given the option to view or hear the cardiac activity and be provided with additional state-mandated information at least 24 hours before an abortion can take place. I understand that violation of these requirements may carry criminal, civil, and/or disciplinary penalties.

I. PPGOH's Provision of Abortion Care

6. PPGOH and its predecessor organizations have served patients in northern, eastern, and central Ohio for decades. PPGOH operates two facilities licensed as ambulatory surgical facilities ("ASFs") under Ohio law.[1] Both facilities provide both medication and procedural

[1] In addition to the two ASFs. PPGOH has 13 health centers that are not ASFs at which a wide range of care is provided, including wellness and preventive care, birth control, pregnancy testing, testing and treatment for sexually transmitted infections, cancer screening, and gender-affirming care, among others. PPGOH also provides care to patients via telehealth through our Virtual Health Center.

abortions. PPGOH's surgical centers are located in Columbus and Bedford Heights (near Cleveland). Both locations provide medication abortions up to 10 weeks, as dated from the first day of a patient's last menstrual period ("LMP"), and procedural abortions through 19 weeks, 6 days LMP.

II. Informed Consent

7. Explaining a contemplated treatment or procedure fully to patients and obtaining informed consent is a core part of medical care. We do this for all care we provide, including testing, medication, and procedures. PPGOH takes a patient-centered approach to informed consent, which involves engaging the patient in the decision-making process. With each patient, we thoroughly discuss the specific care they are considering, including its risks, benefits, and alternatives. Throughout the informed consent process, we answer patients' questions and take whatever steps are necessary for them to fully understand their treatment.

8. PPGOH has resources in place to allow us to engage fully in this process with clients for whom English is not a primary language, who are more comfortable receiving medical information in another language, or who communicate via American Sign Language ("ASL"). PPGOH routinely uses a telephonic interpreter service to fully interpret meetings with patients. We keep translated written materials on hand in the languages other than English that our patients most commonly speak. We also have access to written translations in languages PPGOH encounters less frequently. We can download and print these for patients and/or include them in the translated materials in their electronic medical record, to which patients have access. PPGOH also has iPads for patients who communicate through ASL.

9. PPGOH staff are trained to evaluate every patient to ensure the patient is making a voluntary and informed decision. In addition to asking questions aimed at assessing this at several points in the care process, PPGOH staff are trained to observe patients and their interactions with

anyone present at their appointment for non-verbal signs of coercion. PPGOH completes an intimate partner violence ("IPV") screening for all patients—not just those who come to us for abortion care. PPGOH employs patient navigators who are trained to work with patients experiencing IPV and other dangerous or challenging life circumstances and help connect them with additional information and resources. We also keep written information about resources for people experiencing IPV available in every patient room.

10. Almost all patients who come to one of PPGOH's ASFs for abortion care are already certain about their decision to have an abortion. Before arriving at one of our clinics, patients have scheduled an appointment, made any necessary child care and/or work arrangements, traveled to one of our ASFs, and endured harassment from protesters outside the clinic. In my experience, patients think about their decision throughout this process, and the vast majority are certain when they walk through our doors. Having an abortion is simply not something patients do impulsively or without thought. If at any point a patient expresses hesitance or uncertainty, however, we emphasize that they do not have to go through with the process. We provide patients with nonjudgmental education and information to assist them in their decision-making, and we encourage patients to take as much time as they need to consider any medical decision, including abortion. We also let patients know that they can always reschedule any appointment and return another day if they wish.

III. Harm to Patients

11. The Challenged Requirements force patients to meet with a physician twice, even though two visits are not medically necessary, and to delay their abortion care for at least 24 hours, even though such delay is also not medically necessary and may actually harm patient health. Forcing patients to incur the physical, financial, emotional, and social costs the Challenged

Requirements exact is both unnecessary and harmful, and provides absolutely no benefit to patient health or safety.

12. PPGOH's patients come from Ohio and other states. Even our Ohio patients may struggle to arrange travel to Columbus or Bedford Heights for care if they do not have a car and live in a neighborhood with poor public transportation, or if they do not live in either city where PPGOH has an ASF. For example, traveling from the Mansfield area to one of our ASFs requires driving approximately 75 miles each way, and traveling from the Norwalk area to our Bedford Heights ASF is an approximately 63-mile drive each way. Other abortion providers in the state are no closer. For out-of-state patients, the time and expense required to travel to Ohio for an abortion can increase exponentially.

13. Patients without a car need to rely on others to borrow one or give them a ride, or somehow cobble together the trip without a car (i.e., using a mix of public transportation and paid fares). In addition to posing logistical challenges, this can result in patients having to disclose to several people that they need assistance getting to their abortion appointment.

14. Due to the Challenged Requirements, patients who could otherwise obtain their abortion at their first visit are forced to return to the clinic for a second appointment. This means that those patients who need to travel long distances within Ohio or from out of state to get to the clinic will need to either arrange and pay for overnight accommodations near the clinic or arrange and pay for transportation twice. For some of these patients, this could even be their third or fourth medical appointment, if they have already had one appointment, or more, at health centers in their home state only to be told they could not receive abortion care near home. Even setting aside the travel distance, being forced to make two or more trips to the clinic for care can be extremely burdensome—on top of any necessary travel or accommodation costs, patients may also have to

forgo a second day of wages (as many of our patients do not have paid time off) or unnecessarily consume earned leave time, risk jeopardizing their employment by taking multiple days off work, and/or arrange and pay for additional child care.

15. PPGOH has recently begun piloting a program in which eligible medication abortion patients can have their second appointment via telehealth. However, these patients still have to make a first, in-person visit to the clinic, and then wait at least 24 hours before they can actually undergo an abortion. While this program reduces the travel burdens for a small subset of patients (i.e., medication abortion patients who are eligible), it cannot address all the burdens that flow from the mandatory delay. Indeed, many of our patients are unable to do virtual appointments, including: patients without the privacy necessary for a home visit, patients without reliable internet access, and patients seeking procedural abortions. As such, the vast majority of abortion patients must still make two separate visits to our clinics to obtain abortion care, for no legitimate medical reason.

16. The majority of PPGOH's patients already have children and therefore must arrange and pay for child care in order to attend their appointments. This means that some of our patients who are single parents may need to tell two or more people that they need to travel for their appointment either to have someone care for their children near home or to travel with them to care for their children during their appointment. This can compromise the confidentiality of their pregnancy and abortion decision. Other parent-patients must bring their children to their appointments because they have no child care options. This increases travel-related costs (e.g., an extra bus ticket, needing a larger hotel room, higher food costs to feed more people, etc.) and requires a reliable support person to agree to take time out of their day to accompany the patient

to their appointment and serve dual roles of escort and child care provider while the patient is receiving care. Not every patient has such support available.

17. The burdens associated with the Challenged Requirements, while significant for all of our patients, are especially difficult for patients who have less stability in their daily lives. For example, patients who are experiencing IPV have immense difficulty navigating multiple medical appointments without being detected by the person who is abusing them—this includes not only finding a way to explain their physical absence, but also obtaining transportation and the funds needed to pay for travel and the abortion care itself. This can endanger the patient, who may experience physical, sexual, or emotional violence if detected, and who might thereafter be subjected to heightened physical and/or emotional control by the person who is abusing them.

18. **The Challenged Requirements are also especially burdensome for our patients who** are experiencing homelessness. Needing to travel even once for care is already tremendously difficult for people who do not have a safe, private place to live, or who do not have a secure place to store belongings that they cannot bring with them. Requiring two appointments compounds this. In my experience, patients experiencing homelessness sometimes struggle more than other patients to come to an appointment at a scheduled time and may not be able to use online scheduling systems to make or reschedule appointments. The difficulty can be especially acute for patients experiencing homelessness who work and have children. These patients face all the same difficulties as other working and parenting patients face related to needing to take time off work and find child care, but with added risk and fear that come with navigating those dynamics with little to no safety net.

19. The financial burdens described above are also especially onerous for our patients living on low incomes or experiencing poverty. For such patients, this can mean forgoing basic needs, like having food to eat or hygiene products to use, in order to obtain care.

20. Young adults, especially students, who have limited financial and transportation resources and often live away from their support system or are traveling for summer internships also have a particularly challenging time traveling to obtain the care they need.

21. The Challenged Requirements' effect of pushing patients later into their pregnancies and forcing them to remain pregnant against their will longer also harms patients' health and well-being. We have had patients who had previous high-risk pregnancies, or patients with chronic illness, who cannot physically or emotionally endure another pregnancy and suffer needlessly due to a delay in obtaining abortion care. Moreover, while abortion is very safe, its risks increase as pregnancy progresses.

22. Furthermore, delay may impact some patients' ability to have their desired or medically indicated abortion method. For example, some patients strongly prefer medication to procedural abortion but may be pushed past the legal limit for medication abortion in Ohio due to the mandatory delay. Losing the option to have a medication abortion because of the Challenged Requirements can be incredibly distressing for these patients. For example, patients who are pregnant as the result of rape or incest may find the prospect of having medical instruments inserted into their vagina traumatizing and emotionally intolerable. Other patients may need to have a medication abortion based on medical contraindications for procedural abortion, such as an allergy to sedation medications, seizure disorder, or anatomic structural variations, and thus may be unable to access abortion altogether in Ohio.

23. Patients whose treatment is unnecessarily delayed by the Challenged Requirements may also be pushed to a point in their pregnancies at which overnight cervical dilation is necessary prior to a procedural abortion. This adds an additional step and means that a patient needs to come to the clinic three times, rather than two. These patients, rather than having their procedural abortion in a single day, have two procedure-related visits after their initial appointment and the mandatory waiting period—one to begin cervical dilation and a second for the procedural abortion.

24. For many patients, the Challenged Requirements end up delaying care for far longer than 24 hours in practice due to personal circumstances, such as the challenges described above, and appointment availability.

25. Even though we describe the 24-hour waiting period when patients make appointments, some patients express confusion when they come to the clinic about why they cannot get an abortion at their first appointment. Patients often express anguish when we tell them that state law requires us to delay their care, which I believe reflects feelings of stigma that patients experience when reminded that abortion care is treated differently than other medical care, despite how safe and common it is.

26. Indeed, patients who come to one of PPGOH's ASFs for abortion care experience stigma every time they come to one of our clinics. Every day, protesters gather outside of both of our ASFs—often in groups so large they line the street or fence outside the clinic. The crowds that gather hold up signs and graphic photos and scream at our patients, including through bullhorns. At PPGOH's Columbus ASF, there is no way for patients to access the clinic except through the throng of protesters that have assembled that day. At our Bedford Heights ASF, patients are able to park behind the clinic and enter through a protected entrance away from the street, but they still have to travel past protesters on the way in. Needing to park and enter behind the clinic to avoid

protesters, while better than having to walk through a line of screaming protesters, is still a stigmatizing experience for patients. The Challenged Requirements exacerbate this stigma for patients who have to endure this experience two, or even three, times in order to have an abortion.

27. Requiring providers to tell patients about embryonic or fetal cardiac activity, whether or not the patient wants that information, can also make patients feel stigmatized, judged, or belittled and can decrease a patient's comfort and trust with the provider. This can be further traumatizing and triggering for patients who are pregnant as a result of rape or IPV and can create unnecessary additional emotional pain and distress. This is particularly true for patients who are certain they want to have an abortion, have expressed that to the provider, and are still forced to sit through state-mandated statements that have no medical purpose. Patients have expressed feeling stigmatized and infantilized by the forced information.

IV. Harm to Staff and Operations

28. The Challenged Requirements negatively impact PPGOH's staff by forcing them to comply with requirements that do not advance patient health and, in fact, harm patients. Having to delay providing their patients with time-sensitive medical care, which is contrary to the standard of care and their best medical judgment, is incredibly distressing to providers who know they could be providing better care than Ohio law allows. Additionally, being forced to provide patients with medically irrelevant, non-evidence-based, and, in some instances, inaccurate information that makes patients feel stigmatized, judged, or belittled is emotionally painful for PPGOH's providers, who are committed to providing evidence-based, compassionate care. It is also upsetting to PPGOH's staff to have to make patients return to the clinic, knowing the financial, social, and emotional costs that carries, when there is no medical reason the patient needs to do so. The Challenged Requirements force PPGOH's staff to be complicit in inflicting the laws' harms. Knowing this, and seeing the pain it causes patients, harms our staff.

29. The Challenged Requirements also negatively impact PPGOH's operations by requiring us to have physicians meet with patients more times than is medically necessary. This burdens PPGOH's schedule and limits the number of patients to whom we can provide care since each patient needs to meet with a physician twice. PPGOH and its patients also have to navigate scheduling challenges to ensure the patient is available for their second scheduled appointment.

The undersigned hereby affirms that the statements made in the foregoing affidavit are true, under penalty of perjury.

Adarsh Krishen, M.D.

State of Florida
County of Pinellas

The foregoing ~~instrument was a~~knowledged before me by means of physical presence this 27th day of March 2024 by Adarsh E. Krishen who is personally known to me ~~(or who has produced a Florida drivers license as identification N/A)~~.

Sworn to and subscribed before me this 27th day of March, 2024 in Pinellas County, Florida.

Notary Public
Marcella Calhoun Gridley
Notary Public
Comission #HH025219
My commission expires August 17, 2024

MARCELLA CALHOUN GRIDLEY
Notary Public - State of Florida
Commission # HH 025219
My Comm. Expires Aug 17, 2024
Bonded through National Notary Assn.

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

PRETERM-CLEVELAND, *et al.*, *Plaintiffs*, v. DAVE YOST, *et al.*, *Defendants.*	Case No. Judge

AFFIDAVIT OF CATHERINE ROMANOS, M.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Catherine Romanos, M.D., having been duly sworn and cautioned according to law, hereby state that I am over the age of 18 years and am competent to testify as to the facts set forth below based on my personal knowledge:

I. Background and Qualifications

1. I am a board certified family medicine physician licensed to practice medicine in Ohio and currently employed at Women's Med Center Dayton ("WMCD"), where I began providing care in 2018. I received my medical degree from the University of Connecticut in 2007 and completed my residency in family medicine in Massachusetts, with a focus on social justice and caring for underserved populations.

2. For three years after completing my training, I was on the faculty at a residency program at the Greater Lawrence Family Health Center, providing inpatient and outpatient family medicine care. In that role, I provided care to adult patients, pregnant people, and babies. I was able to work across a variety of settings including inpatient medicine, the intensive care unit, inpatient pediatric care, and obstetrics.

3. I provided abortion and complex contraception care at Planned Parenthood of Greater Ohio from 2013 to 2018.

4. WMCD provides procedural abortions (sometimes called "surgical abortions")[1] through 21 weeks, 6 days as dated from the first day of a patient's last menstrual period ("LMP") and medication abortions up to 70 days (10 weeks) LMP. WMCD is the only abortion provider in the Dayton, Ohio area, and one of only nine abortion clinics in the state. WMCD is one of only three clinics that provide care up to the legal limit in Ohio.

5. In my role as a physician at WMCD, I oversee the care of patients at the clinic, which includes meeting with and counseling patients, reviewing and signing off on a variety of documentation and records such as ultrasounds, medical histories, laboratory tests, and outside records. I also provide abortions.

6. WCMD's patient population roughly reflects the known demographics of abortion patients nationwide. Nationally, approximately three-quarters of people seeking abortion care are poor or low income.[2] A majority identify as people of color, including over half who identify as Black or Hispanic.[3] Roughly two-thirds of abortion patients already have given birth at least once.[4] At WMCD, the majority of our patients are under 30 years of age, in their first trimester of pregnancy, and live at or below the federal poverty line.

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[1] Procedural abortion is not commonly understood to be "surgery" because it involves no incision and no need for a sterile operating room.

[2] Rachel K. Jones & Doris W. Chiu, *Characteristics of Abortion Patients in Protected and Restricted States Accessing Clinic-based Care 12 months Prior to the Elimination of the Federal Constitutional Right to Abortion in the United States*, 55 PERSPS. ON SEXUAL & REPROD. HEALTH 82, (2023), https://doi.org/10.1363/psrh.12224 (last visited Mar. 26, 2024); *Induced Abortion in the United States*, Guttmacher Inst., (Sept. 2019), https://www.guttmacher.org/fact-sheet/induced-abortion-united-states (last visited Mar. 26, 2024).

[3] Guttmacher Inst., *supra* note 2.

[4] *Id.*

7. The facts I state here are based on my experience, information obtained in the course of my duties at WMCD, and personal knowledge that I have acquired through my role as a physician. If called and sworn as a witness, I could and would testify competently thereto.

8. I submit this affidavit in support of Plaintiffs' Motion for Preliminary Injunction to block enforcement of Ohio Revised Code Sections 2317.56 and 2919.192–2919.194 (collectively, the "Challenged Requirements").

II. The Challenged Requirements

9. I understand that the Challenged Requirements mandate that, at least 24 hours prior to an abortion, a physician meets with the patient in person to provide certain state-mandated information and an opportunity for the patient to ask questions. Specifically, at this meeting, the physician must inform the pregnant person verbally of the nature and purpose of the abortion as well as associated medical risks, the probable gestational age of the zygote, blastocyte, embryo or fetus, and the medical risks associated with carrying the pregnancy to term. It is my understanding that the law also requires that, at least 24 hours prior to an abortion, the patient be provided the name of the physician performing the abortion, as well as copies of state-produced materials that, among other things, describe fetal development and list agencies that offer alternatives to abortion. It is my understanding that failure to comply with these requirements may lead to a civil action for exemplary damages and/or disciplinary action by the state medical board.

10. It is also my understanding that the Challenged Requirements provide that, at least 24 hours prior to providing an abortion, it must be determined whether there is detectable fetal or embryonic cardiac activity. If such cardiac activity is detected, a patient must be provided with the option to view or hear the cardiac activity and be provided with additional state-mandated information regarding the existence of the cardiac activity and the statistical

probability of carrying the embryo or fetus to term based solely on gestational age, and sign an acknowledgment of receipt of said information. It is my understanding that the failure to comply with these requirements can result in criminal, civil, and/or disciplinary penalties.

11. I am also familiar with the medical emergency/necessity exceptions to the Challenged Requirements, under which a physician may be exempt from complying in very narrowly defined cases of "medical emergency," and/or "medical necessity." At WMCD, we do not perform abortions in reliance on these narrow exceptions due to the legal and administrative risks of doing so, given how extremely narrow and vague the definitions of "medical emergency" and "medical necessity" are. Notably, the Challenged Requirements contain no exception for cases where an abortion is medically indicated but not rising to the level of medical emergency or necessity, and no exceptions for patients who have become pregnant as a result of sexual assault or incest, or where the patient is seeking to terminate a wanted pregnancy after the diagnosis of a fatal fetal condition.

12. I am familiar with the Challenged Requirements because I am responsible for complying with them in my professional practice.

13. As a result of the Challenged Requirements, WMCD's patients must make at least two separate trips to WMCD in order to have an abortion, and also must delay their abortion care by at least 24 hours (if not longer) following their first appointment (the "Waiting Period and In-Person Requirements"). Our patients are also forced to receive state-mandated information that is not only irrelevant to their provision of informed consent, but also may be distressing, stigmatizing, or even misleading (the "State Information Requirement"). In my opinion, these medically unnecessary requirements burden, interfere with, and discriminate against our patients seeking abortion care and our clinic staff who wish to assist them in doing so.

III. Abortion Methods and Safety

14. Abortion is extremely common in the United States: approximately one in four women in this country will have an abortion by age 45.[5]

15. People seek abortion care for a wide variety of often overlapping reasons, depending on their personal life experience. The decision to continue a pregnancy, seek an abortion, and/or parent a child is informed by individual values, beliefs, culture and religion, family circumstances, economic circumstances, access to resources, reproductive history, and physical and mental health concerns. My patients often share their own particular reasons with me, which generally match what we know from research about the variety and complexity of reasons someone might seek abortion care. On average, patients express as many as five reasons why they are seeking an abortion, which can include things like the cost of giving birth to and raising a child, the need to provide for children already in the home, concerns with relationship stability or health, desire to pursue education or career goals, and concerns about their own health or mental well-being during pregnancy or childbirth.[6]

16. I provide two types of abortion care at WMCD: medication abortion and procedural abortion.

17. The most common form of medication abortion involves the use of a two-drug regimen—mifepristone and misoprostol—to essentially induce the body to miscarry. Although medication abortion is a safe and effective way to terminate a pregnancy through at least 11 weeks LMP, Ohio law prohibits its use after 10 weeks and 0 days LMP. For medication abortion,

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[5] Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 AM. J. PUB. HEALTH 1904, 1907 (2017).

[6] Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 PERSPS. ON SEXUAL & REPROD. HEALTH 110–118 (2005), https://www.guttmacher.org/journals/psrh/2005/reasons-us-women-have-abortions-quantitative-and-qualitative-perspectives (last visited Mar. 26, 2024).

the patient ingests the first medication, mifepristone, which prevents the pregnancy from continuing to develop. Then, 24 to 48 hours later, the patient takes misoprostol, which causes bleeding and contractions that empty the contents of the uterus.

18. Procedural abortion involves the use of instruments to end the pregnancy and empty the uterus. This may include the use of aspiration (suction) and/or other instruments to evacuate the uterus.

19. Abortion is among the safest outpatient procedures performed in the United States, and deaths associated with abortion are exceedingly rare.[7] Complications from abortion care are also rare and can generally be safely and effectively managed in an outpatient clinic setting, either at the time of the abortion or at a follow-up visit. Abortion is also significantly safer than childbirth: the risk of maternal death associated with childbirth is approximately 12 to 14 times higher than the risk of death associated with legal abortion.[8] In addition to childbirth, colonoscopies, certain dental procedures, and plastic surgery—procedures that are commonly

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[7] *The Safety and Quality of Abortion Care in the United States*, NAT'L ACADEMIES OF SCIENCE, ENGINEERING & MEDICINE 74–75 (2018), available at https://nap.nationalacademies.org/read/24950/chapter/1 (accessed Mar. 26, 2024) [hereinafter "Nat'l Academies Report"]; Daniel Grossman & Kate Grindlay, *Safety of Medical Abortion Provided Through Telemedicine Compared with in Person*, 130 OBSTETRICS & GYNECOLOGY 778, 779–80 (2017) (finding that 0.26% of patients in the study experienced clinically significant adverse events, defining significant adverse events as those that required treatment given in an emergency department, hospital admission, surgery, blood transfusion or death, and finding zero incidents of reported deaths or need for surgery); Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 OBSTETRICS & GYNECOLOGY 175, 178, 181 (2015) (finding a 0.31% risk of major complications for medication abortion and 0.16% for first trimester aspiration abortion and defining major complications as those unexpected adverse events that required hospital admission, surgery, or blood transfusion); Kelly Cleland et al., *Significant Adverse Events and Outcomes After Medical Abortion*, 121 OBSTETRICS & GYNECOLOGY 166, 169 (2013)(finding that 0.06% of patients experienced complications resulting in hospital admission; the rate for transfusion was 0.05%); Tracy A. Weitz et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 AM. J. PUB. HEALTH 454, 458 (2013) (finding that first-trimester abortion is one of the safest medical procedures and carries minimal risk—0.05%—of major complications).

[8] Nat'l Academies Report at 74–75.

performed in ambulatory surgical facilities ("ASFs") or freestanding clinics—all have higher mortality rates than abortion.[9]

IV. Informed Consent in Abortion Care

A. Informed Consent in General

20. From the earliest stages of medical training and through all subsequent education, observation, and practice, the process of obtaining informed consent from patients is learned, practiced, and refined to the point that it becomes second nature. In my early education, I learned the ethics and theory behind informed consent requirements. As I proceeded through my advanced training, I participated in practicums and was observed providing clinical care so that I could fully develop the skills of ensuring informed consent that I continue to use daily in my practice. I also routinely observe, train, and advise other non-physician clinical staff (e.g., nurses and medical technicians) and younger physicians on their own ethical informed consent practices in accordance with standard of care as a part of my supervision of residents.

21. Informed consent arises from the medical ethical obligation to respect the self-determination and bodily autonomy of our patients. Every patient must receive complete, accurate, and accessible information about the nature and purpose of a proposed procedure or treatment, as well as its risks, benefits, and any available alternatives, in order to independently and voluntarily consent or refuse to proceed.

22. The provision of information necessary to informed consent and the obtaining of that consent generally occurs shortly before a medical procedure or treatment, and there is no need to force patients who are already certain of their care decisions to delay or go home and think about it for additional time. This is true even for procedures during pregnancy such as

[9] *Id.* at 75.

amniocentesis or chorionic villus sampling, both of which carry the risk of inducing a miscarriage. Even in cases of major abdominal surgery such as a non-emergency cesarean section, the patient is able to consent to the procedure on the same day.

23. An important part of my role as a health care provider includes understanding my patients' needs and wishes, educating them about their options, and counseling them through sometimes complicated decisions. I help address and assuage any fears or uncertainties patients bring into my office, answer any questions they have, and ensure they comprehend the medical information relevant to their treatment. It is also integral to my role that I am educated and able to detect any signs of undue influence, coercion, or hesitancy on the part of my patients so that I may address it and account for any such concerns in my counseling and any next steps.

24. In order to ensure patient self-determination and autonomy, a physician must meet patients where they are when discussing care options and patient concerns. In my discussions, I take into account the specific needs of the patient; the complexity of the medical information to be provided; the patient's concerns, circumstances or preferences; and anything else that might impact their decision-making process. For example, procedural abortion may pose greater risks than medication abortion for certain patients based on their anatomy and prior medical history. Likewise, a patient's particular living situation—such as homelessness or living with an abusive partner—may figure into the risks and benefits of an abortion, or a particular method of abortion.

25. Indeed, the American Medical Association's ("AMA") Code of Medical Ethics guidance dictates that the informed consent process should take account of a patient's individual circumstances and physicians should tailor the information they provide to the patient's needs and expectations.[10] Similarly, the American College of Obstetricians and Gynecologists

("ACOG"), the nation's leading professional association of obstetricians and gynecologists, has issued clinical guidance making clear that "[t]he highest ethical standard for adequacy of clinical information requires that the amount and complexity of information be tailored to the desires of the individual patient and to the patient's ability to understand this information."[11]

26. Although it is best medical practice to tailor an informed consent discussion in this way, under Ohio law, the State mandates many things that must be told to abortion patients, without the flexibility to account for the best interests or humanity of those patients. I do not view forcing information on my patients that is both unnecessary to their informed decision-making and may only serve to harm or distress them as providing the best medical care in line with ethical medical practice.

B. Informed Consent at WMCD

27. At WMCD, we ensure that each and every patient seeking care or treatment goes through an informed consent process and provides fully informed and voluntary consent to any treatment or procedure we provide, and we would continue to do this as part of the standard of care and best medical practice regardless of whether Ohio law imposed any specific requirements.

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[10] Am. Med. Ass'n, Code of Medical Ethics, *Withholding Information from Patients*, Op. No. 2.1.3, https://code-medical-ethics.ama-assn.org/ethics-opinions/withholding-information-patients (last visited Mar. 26, 2024).

[11] Am. Coll. of Obstetricians & Gynecologists, Committee on Ethics Op. No. 819 (Feb. 2021), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2021/02/informed-consent-and-shared-decision-making-in-obstetrics-and-gynecology.pdf (last visited Mar. 26, 2024). The American Medical Association's ("AMA") Code of Medical Ethics guidance also dictates that the informed consent process should take account of a patient's individual circumstances and physicians should tailor the information they provide to the patient's needs and expectations. Am. Med. Ass'n, Code of Medical Ethics, *Withholding Information from Patients*, Op. No. 2.1.3, https://code-medical-ethics.ama-assn.org/ethics-opinions/withholding-information-patients (last visited Mar. 26, 2024).

28. When patients arrive at WMCD for their first abortion appointment, they interact with a number of medical staff, patient educators, and a physician. Each of these trained staff members is a resource for patients to ask questions and to discuss their individual history, concerns, and preferences. Patients meet with a nurse or medical assistant who takes their initial health history and performs any necessary laboratory tests or vitals checks. The patient is also given an ultrasound (which the client may view, hear, or photograph if they so choose), which is performed by either the nurse or an ultrasound trained medical assistant.

29. After these steps are completed, patients meet with a patient educator who discusses the method of abortion care that is to be provided and answers any questions or concerns the patient might have, works through any logistical or financial barriers the patient may be facing, and describes the birth control options available to the patient after their abortion if they are interested.

30. In general, WMCD patients have private, one-on-one interactions with at least two or three separate staff members prior to meeting with the physician. Patients are able to ask questions and share any concerns or hesitancy about their care with any staff member and are provided several private opportunities to do so even before they meet with the physician.

31. Finally, the patient has a one-on-one meeting with the physician to discuss any remaining questions the patient might have and to ensure the patient is able and willing to provide informed consent for the procedure. At this point, the physician provides the state-mandated information referenced above. Where embryonic or fetal cardiac activity has been detected, the physician also obtains the patient's signature acknowledging that they have been notified of it and the statistical probability of carrying the pregnancy to term, based on the gestational age.

32. The most common questions I receive from patients are regarding whether abortion is dangerous (it is not) and whether they are at risk of criminalization or investigation for seeking care at WMCD (they are not). In my experience, in the overwhelming majority of cases, once a patient is able to meet with clinic staff and talk through the risks, benefits, and alternatives to abortion, they are empowered and reaffirmed in knowing that they have made the right decision, or have the information that they need to make that decision. We take care to ensure that our patients are able to engage collaboratively in the informed consent process, including ensuring language access. I am proficient in Spanish, and frequently the clinic will schedule Spanish-speaking patients with me to ensure their accessibility to the collaborative consent process. For patients who do not speak English, we also use a telephonic translation service to translate each step of this process for them.

33. From the first point of contact that a prospective patient has with WMCD through the abortion the patient obtains, every staff member who interacts with the patient is on the lookout for any hesitancy, uncertainty, or signs of coercion to ensure the patient is fully informed and comfortable with their decision.

34. At WMCD, if we know, or even if we have any reason to suspect, that the patient is being coerced or pressured into obtaining an abortion, we investigate that concern privately with the patient and follow their wishes, regardless of the wishes of anyone else who may have accompanied them to their appointment.

35. If I or my colleagues notice any hesitancy, we follow up with the patient and open up further discussion until they feel comfortable with their decision, whatever that may be. If I sense that the patient may be rushing through a decision, I assure them that we can always reschedule them if they want to take more time. I may also offer to refer them to additional

options counseling resources such as the All Options Talkline or trustworthy and nondirective online resources. Neither I nor any of the other physicians at WMCD would ever proceed with an abortion without the free, informed, and voluntary consent of the patient. And while I find that engaging in caring, open, and nonjudgmental discussions with patients encourages them to share their concerns, thus helping me to probe whether any coercion or uncertainty is present, I have never found that the state-mandated two-trip, waiting period, or informational requirements aid in this process. On the contrary, as I discuss below, these requirements create barriers to and serve to undermine the physician-patient relationship of trust that I work to cultivate with my patients.

36. While patients can change their mind at any point prior to receiving their abortion, the vast majority have already thought long and hard about their decisions and have already made up their mind by the time they contact us. Moreover, in my experience, none of the Challenged Requirements makes any difference for patients in their decision making process.

37. I am not aware of any other similarly time-sensitive medical procedure that requires a waiting period by law, nor am I aware of any other medical procedure that requires the patient to make a separate, in-person visit for informed consent, or for which physicians are prohibited from using their best medical judgment as to which information to convey to a patient based on that individual patient's circumstances and needs.

V. The Challenged Requirements Burden and Harm WMCD's Patients

38. The Challenged Requirements undermine, rather than reinforce, patient self-determination and autonomy. Patients who are comfortable with their decision are made to delay care unnecessarily–that is, for absolutely *no* medical reason—based on paternalistic and insulting ideas about women's moral agency, and specifically their ability to make decisions about their pregnancies. This delay not only risks patients' health and well-being, but also effectively strips

them of their autonomy to receive timely care that they and their physician agree is appropriate. Moreover, my patients face so many logistical barriers associated with accessing abortion care and attending an appointment that—when forced to delay care and make an additional, unnecessary trip to the clinic—many struggle to climb that mountain again.

A. The Waiting Period & In-Person Requirements

39. The treatments for early miscarriage (also called early pregnancy loss), including the use of medications or aspiration, are identical to those for abortion. Yet, if my patient is suffering early pregnancy loss, I can legally treat them on the same day that I obtain informed consent and am not required to enforce a waiting period or force patients to make a second trip back to the clinic, as is required for abortion. This allows me to provide timely and efficient miscarriage care, without the interference of burdensome delays and barriers that are imposed on abortion care.

40. Similarly, when I am obtaining informed consent for other routine reproductive health care, such as the insertion of an intrauterine device ("IUD"), I am able to operate under the general medical informed consent principles embodied in the standard of care, medical ethics, and state law and use my best medical judgment in tailoring the discussion to the needs of each specific patient to ensure they receive high quality and timely care. I am able to collaborate with my patient to determine an appropriate timeline for their care, which may include same-day insertion or treatment without the interference of a mandatory and arbitrary delay.

41. People seeking abortion face myriad barriers to accessing care, even under the most ideal circumstances. Since the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* in June 2022, I have seen an increase in the proportion of patients who are traveling to WMCD from out of state, as well as a higher proportion of patients seeking abortion care later in their pregnancies. I believe that these changes in patient population are largely due

to the total loss of access to abortion in neighboring states such as Indiana, Kentucky, and Tennessee and to the increase in outright bans or gestational age limits on abortion in other states, both of which increasingly force patients to travel hundreds of miles to access reproductive health care. These changes in surrounding states impact abortion seekers in Ohio by making it more difficult for them to get appointments at Ohio clinics. Patients must compete for access to an ever-shrinking number of abortion providers and (as a result) are pushed later into their pregnancies as they struggle to secure (and pay and travel for) care. As one of the few clinics in the region providing abortion care into the second trimester, WMCD has seen an increase in the demand for later care.

42. In general, by the time patients attend their first appointment at WMCD, they have already spent significant time considering their decision and considerable resources to reach the clinic at all. Nevertheless, as a result of the 24-hour waiting period, the patient must wait *at least* another 24 hours before returning for their abortion procedure or to receive the abortion medication. However, in my experience, more often than not, the patient is delayed much longer than the mandatory 24 hours.

43. Sometimes Ohio's restrictive laws overlap, forcing patients to make *three* trips to the clinic rather than two. For example, a patient who presents at around five weeks LMP may not have detectable embryonic or fetal cardiac activity at their first appointment. The patient will have to wait at least 24 hours after having received the state mandated information required to be given at their first appointment before returning for a second appointment, ostensibly to obtain their abortion care. However, if cardiac activity is detected for the first time during the second appointment, the patient will have to wait an *additional* 24 hours after having received the

additional state mandated information, before they are able to return once again for a *third* visit to actually obtain their abortion.

44. Traveling to an abortion clinic is extremely challenging for many patients, even if a clinic is relatively close. Patients often must obtain time off from work (which may mean forgoing wages), find and potentially pay for child care, coordinate around their or their children's school schedules, as well as find and pay for any required transportation. In my experience, patients are frequently forced to delay care in order to obtain the necessary financial support and finalize the logistics of work, school schedules, and child care.

45. For many of our abortion patients who are poor or low-income and who often do not have paid time off, it is common to have to wait much longer than 24 hours before they can find time for a second appointment that accommodates their work schedule, so as not to lose wages or even risk losing their employment altogether for taking unauthorized time off.

46. For the majority of patients who already have at least one child, obtaining and affording child care for multiple appointments can be a serious barrier to access. Appointments at WMCD frequently last several hours each, which means multiple hours of child care over multiple days. The cost of child care alone is often a barrier for patients living at or below the poverty line.

47. For patients who require assistance to and from their local abortion clinic, this adds another layer of complexity to the scheduling, as it requires a second person who is able to drive and be away from work during the middle of the day, or the patient is forced to rely on unpredictable and fractured public transit systems. There are many reasons a patient may need such assistance. Frequently, patients seeking procedural abortion care want to be given sedation

for the procedure and, as a result, will need someone able to drive them home from WMCD after their care is complete.

48. For patients who don't live near an abortion clinic or who must leave their home state to access care, being forced to delay care and make two trips to the clinic can make an already traumatic and difficult situation significantly worse. I had one patient who traveled several hours to WMCD by herself and—because I was forced to make her wait for 24 hours between her first visit and her procedure—had to spend the night in her car in a McDonald's parking lot because she had nowhere else to stay.

49. Similarly, I counseled a couple who had received a devastating fetal diagnosis and had to do everything they could to locate our clinic on their own because their local provider refused to provide them with any information or assistance with terminating the pregnancy. That couple arrived at our clinic having already thoroughly researched their options and simply did not need additional time to be certain of their decision.

50. I also cared for a patient who was serving in the military and stationed in the Middle East when she found out she was pregnant. She flew halfway across the world to come home to Ohio for a first-trimester abortion so that she could continue to serve in the military. It was extremely distressing, for both myself and the patient, to have to send her away to wait an additional 24 hours. This woman, who had just taken four flights to access an abortion, did not need any additional time to think about her decision.

51. Even for patients who have access to sufficient professional and financial resources to be able to attend the first available appointment at the clinic, the delay can be significantly longer, depending on the patient's personal circumstances and the type of care they need. For example, WMCD schedules most procedural abortions in the morning. Thus, a patient

who comes in for their first appointment in the afternoon would not be able to return to the clinic the following afternoon (e.g., just under 24 hours later) for care; rather, they wouldn't be able to come in until the morning at least two days later (thus over 24 hours). We make every effort to make scheduling easier on patients but we simply cannot meet the demand for services.

52. However, in reality almost every patient faces some compounding of scheduling, personal, logistical, and/or financial barriers to making it back to the clinic for a second appointment. Thus, what appears to be a mandatory 24-hour delay can, in practice, become a delay of several days, if not weeks, due to the difficulty of scheduling second or third appointments for a time when the patient has both work coverage and child care. This intersection of legal, logistical, and financial barriers can create a compounding cycle of delay. The cost of abortion care generally increases as a pregnancy progresses,[12] which in turn creates an additional financial barrier for that patient, requiring them to wait even longer to raise sufficient funds for the more expensive care. In fact, patients may be pushed beyond the legal limit of care due to this compounding cycle of delay.

53. My patients are often distraught at the realization that they will have to once again make logistical and financial arrangements to return in order to obtain their abortion. They tell me, for example, that they can't come back until next week because they only get paid every other week; that they can't take another whole day off of work.

54. The lengthy delays that result from these compounding barriers can also put a preferred abortion method out of reach for a patient, or require a longer and more complicated procedure. A patient who has a first appointment at 7 weeks, 6 days LMP can easily end up

[12] After the first trimester, the cost of care increases significantly roughly every two weeks. For patients already later in their pregnancies due to a recently diagnosed fetal condition or delays in getting to the clinic due to difficulties traveling long distances, these costs can easily reach thousands of dollars.

delayed past the 10-week cutoff for medication abortion in Ohio. Likewise, a patient who initially presents close to 16 weeks LMP can–as a result of the delay–end up needing a two-day abortion procedure instead of a single-day procedure, which results in three separate visits to the clinic and all the attending costs and burdens. A patient facing a recent fetal diagnosis at 20 weeks LMP—when pregnant patients often receive a fetal anatomy scan at which certain fetal conditions are discovered—may struggle to navigate the abortion care landscape or raise funds before hitting Ohio's legal abortion limit of 22 weeks LMP.

55. For patients who are very early in pregnancy—so early that the pregnancy cannot be detected on the ultrasound—it can be difficult to determine whether we are terminating an intrauterine pregnancy, or whether the patient has a very early, asymptomatic ectopic pregnancy. The best medical course of treatment in this situation is to provide the abortion medication or perform the procedure immediately and then follow the trend of their pregnancy hormone levels immediately after the abortion.[13] If the pregnancy hormones drop significantly, no further care is needed, but if they rise, this may indicate an ectopic pregnancy requiring immediate follow-up. Having to wait an additional 24 hours to begin the abortion in a situation like this can unnecessarily delay the diagnosis of the ectopic pregnancy. Delay in diagnosis of an ectopic pregnancy can mean the difference between treating the patient with medication, as is possible with early detection, or the patient needing abdominal surgery, if diagnosis is delayed.

56. While abortion, even later in pregnancy, is always extremely safe, and much safer than childbirth, the risks associated with abortion do increase as pregnancy progresses. Mainstream medical consensus dictates that the best medical practice is to provide patients with timely abortion care without any unnecessary delays, and that mandatory waiting periods for

[13] Anne N. Flynn et al., *Prioritizing Desiredness in Pregnancy of Unknown Location*, 136 OBSTETRICS & GYNECOLOGY 1001 (Nov. 2020).

abortion do not improve patient health. Indeed, according to the National Academies of Sciences, Engineering, and Medicine (the "National Academies"), "[t]he clinical evidence . . . on the provision of safe and high-quality abortion care stands in contrast to the extensive regulatory requirements that state laws impose on the provision of abortion services," including laws that impose "waiting periods" for receiving abortion care.[14]

57. Moreover, pregnancy also carries its own side effects and risks, which abortion patients who are delayed in accessing timely care will be subjected to for longer than necessary. For example, I regularly see patients who have a diagnosis of hyperemesis gravidarum ("HG"), which is when nausea and vomiting from the pregnancy are so severe that patients suffer weight loss and severe dehydration. This diagnosis may require hospitalization and treatment with intravenous fluids and medication. HG patients often have a very difficult time carrying their pregnancies to term and may require hospitalization and steroids for the duration of the pregnancy. For these patients, delaying access to a desired abortion means unnecessarily forcing them to live with the severe and often debilitating symptoms of HG for longer, thereby endangering their health and well-being.

58. Indeed, I have cared for patients who were hospitalized because of HG and came straight from the hospital to attend their first appointment, and then were forced to return to the hospital to wait out the 24-hour delay before I could treat them. This delay also means forcibly subjecting the patient to another 24 hours of very little to no nutrition. Some of these patients are so ill that they have to lie on the floor during the consent process. It is contrary to the standard of care for HG and a breach of my ethical responsibility to my patient to be forced to deny them the care they need when they need it. However, in these cases, the hospital physicians do not feel

[14] Nat'l Academies Report at 77.

comfortable performing the abortion during the patient's admission due to concerns that this would not meet the definition of "life threatening."

59. In my family medicine practice, I would never see a patient with horrible pain and uncontrollable vomiting and not treat the underlying cause of their distress when they ask for treatment. If I see a symptom, it's my job to consider the cause of the symptom and address the cause, not just the symptom, in accordance with my patient's desires and wishes. Yet, the law in Ohio prevents me from providing timely abortion care to a patient suffering from HG. That is not evidence-based or ethical medical care and certainly not what my patients are asking for or deserve.

60. The health risks of delayed abortion care include the impact on underlying health problems, as well as the inherent risks of remaining pregnant. Pregnancy is a stress test for the human body even for patients in the best of health. For a pregnant person who has a preexisting condition or disease, pregnancy can be extremely dangerous, even in the short term. Pregnancy can exacerbate the symptoms of diabetes, hypertension, autoimmune disorders, cardiac disease, and mental health conditions. People with health conditions that have been caused or exacerbated by pregnancy must not only learn to live with and manage these conditions, but also face an even greater risk of experiencing medical complications during pregnancy. In the long term, patients with coexisting conditions who are denied timely abortion care risk negative outcomes including cardiac disease, renal failure, and even stroke.

61. Pregnancy complications are extremely common. Some of the more common complications include preeclampsia, gestational diabetes, and maternal cardiac disease. All of these conditions can result in serious, permanent harm to an individual's health, up to and including death.

62. Some patients with wanted pregnancies receive the diagnoses of a fetal condition later in their pregnancies. I have cared for many such patients who were faced with a heart-wrenching decision they never wanted to make. These patients often endure an agonizing process, balancing information from their prenatal providers, maternal-fetal medicine specialists, genetic counselors, and other resources and discussing their options with their family, faith leaders, and other support systems to come to a resolution that is in the best interests of their family as to whether to continue the pregnancy or seek an abortion. After all of this, forcing such patients to undergo another delay before receiving the procedure they have chosen does not benefit their decision-making process and may only magnify their grief.

63. Additionally, many patients learn of fetal diagnoses during a fetal anatomy scan between 18 and 22 weeks LMP, when fetal organs have developed enough to be visible with an ultrasound. Many patients are delayed in getting an anatomy scan due to long waitlists, and those who receive a diagnosis via their anatomy scan often seek to confirm the diagnosis via amniocentesis. This process of testing and diagnosis itself can require several follow-up appointments within a narrow window between the earliest time of detection at 18 weeks LMP to the legal limit of abortion care in Ohio at 22 weeks LMP. These patients are often struggling to process and grieve a serious diagnosis, while facing a very short timeframe in which they may still be able to access legal abortion care in Ohio. The mandatory waiting period aggravates the difficulty for such patients.

64. The Waiting Period and In-Person Requirements are particularly harmful physically and emotionally to patients who fall into the gaps of legal exceptions. For example, when a patient has miscarried later in pregnancy but embryonic or fetal cardiac activity is detected, their conditions often don't clearly meet the narrow scope of the medical emergency

and necessity exception contained in R.C. 2317.56. As a result, I am obligated to send the patient home in accordance with the mandatory waiting period, which puts them at risk of hemorrhaging and miscarrying at home without any medical care. Indeed, the patient may actually end up suffering the pain and trauma of labor, and even deliver the nonviable fetus while waiting the required 24 hours to have a procedural abortion. This presents a very real health risk to the patient if they miscarry unsupported and has the potential to force them into a dangerous and traumatic birth experience while they are still grieving.

65. I also regularly treat patients for whom their last pregnancy or childbirth experience was so dangerous or traumatic that they are deeply afraid of continuing their pregnancy. My pregnant, Black patients often express fear that they will be unable to obtain qualified, culturally competent medical care in this state. The data suggests that their fears are well founded because Black women in Ohio are two and a half times more likely to die from pregnancy related causes than white women in Ohio.[15] Pregnancy complications such as hypertension, preeclampsia, and diabetes affect Black women at disproportionately high rates and the intersection of pregnancy complications and medical racism can have serious and deadly consequences.[16]

66. It is also common for me to care for patients who are in unsafe living situations or abusive relationships. Coercion through sexual violence and sabotage of birth control is a

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[15] Ohio Dep't of Health, *Racial Disparities in Pregnancy-Related Deaths in Ohio 2008-2016*, (Apr. 2020) https://odh.ohio.gov/wps/wcm/connect/gov/327fd548-7d0c-43ec-9d27-bac48d350150/Racial+Disparities+Snapshot+Final.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-327fd548-7d0c-43ec-9d27-bac48d350150-n7bPjTH (last visited Mar. 26, 2024).

[16] Nat'l Partnership for Women and Families, *Black Woman's Maternal Health: A Multifaceted Approach to Addressing Persistent and Dire Health Disparities*, (Nov. 2023) https://nationalpartnership.org/report/black-womens-maternal-health/#:~:text=Black%20women%20historically%20have%20experienced,hypertension%2C%20preeclampsia%2C%20and%20hemorrhage (last visited Mar. 26, 2024).

common tool of abusive partners that may account for the high incidence of unintended pregnancy among abuse victims. Some people suffering such abuse feel they need to end the pregnancy in order to exit the relationship. For many victims of abuse, abusive partners use pregnancy as a means of ongoing control, and abortion is the victim's only means of permanent escape. When I have to tell patients in these difficult and dangerous situations that they have to leave the clinic and come back after at least 24 hours, I am exposing my patients to additional risks and throwing up unnecessary barriers to desperately needed care. Requiring a patient to attend two medical appointments in a short period of time and mandating providing them specific materials makes hiding the pregnancy and those appointments from their abusive partner significantly harder, which can seriously endanger their safety.

67. Indeed, mainstream medical consensus, as reflected in the positions of leading medical authorities, instructs that laws that impose requirements such as multiple in-person and waiting periods only "delay abortion services, and by doing so may increase the clinical risks and cost of care," as well as "limit women's options for care and impact providers' ability to provide patient-centered care."[17] Moreover, authorities such as the National Academies have recognized that where, as here, a "waiting period is required *after* an in-person counseling appointment, the delay is exacerbated."[18]

68. I see my patients move logistical and financial mountains just to schedule and attend their first appointment. It is inexcusable that I am forced to send them home to overcome those same barriers a second time, often risking not only their health and safety, but also affronting their dignity, in order to access care. For many patients, having to make two trips to the clinic for care is too high a barrier, and too often patients are forced to remain pregnant for

[17] Nat'l Academies Report at 77–78

[18] *Id.* at 78.

weeks or months simply because they couldn't get the day off or find a babysitter on the day when we next have an appointment available on our schedule.

B. The State Information Requirement

69. The State Information Requirement also constitutes a significant burden and interference by inflicting additional trauma, harm, or grief on those who are already dealing with difficult pregnancies.

70. The State Information Requirement forces physicians to provide abortion patients with irrelevant, biased, and even potentially harmful, distressing and/or misleading information. For example, the existence of embryonic or fetal cardiac activity is medically irrelevant for patients who have decided to terminate a pregnancy, as it does not change the nature of the treatment or procedure or impact the potential risks or benefits.

71. Moreover, notably, R.C. 2919.194(A)(2) mandates that physicians tell patients the statistical probability of bringing the pregnancy to term based solely on the gestational age of the embryo or fetus. This, however, is not a calculation that is routinely made by medical professionals who care for pregnant patients, and there is no standard for such a calculation in existing medical literature. To start, standards for this calculation were never promulgated by the Ohio Department of Health as contemplated by R.C. 2919.194(C). In addition, a generalized estimate regarding the statistical probability of carrying to term based solely on gestational age is imperfect and misleading, because it does not accurately reflect the specific circumstances of any given pregnancy. The statute does not appear to permit the physician to take into account any individual patient's circumstances and medical history in making the statistical probability calculation. For example, a patient who has a history of chronic hypertension has a significantly lower likelihood of carrying a subsequent pregnancy to term than any general estimates that must (per the law) be based only on the gestational age of the embryo or fetus would indicate.

72. The state produced materials, which R.C. 2317.56 requires to be provided to patients at least 24 hours in advance of the abortion, present information to patients in a misleading manner that is at best irrelevant, or worse potentially painful or traumatic information solely meant to shame them into not obtaining the abortion.

73. The State Information Requirement sometimes highlights deeply traumatic facets of a patient's individual reproductive health experience. When I treat a patient who is pregnant as the result of rape or incest, they do not need to be reminded of the date of the assault, but by requiring me to inform them of their probable gestational age, the State is forcing me to do exactly that. Such patients are often visibly upset when they have to hear that information in these circumstances.

74. I have also cared for couples who receive severe fetal anomaly diagnoses after several difficult and costly rounds of in vitro fertilization ("IVF") and who are already grieving while seeking abortion care. It is cruel to have to remind them of the exact gestational age of the pregnancy. They already know very well *exactly* when they got pregnant. Patients who are carrying a nonviable pregnancy often experience shame about being unable to carry a healthy pregnancy to term (regardless of the fact that they are not to blame), and the State Information Requirements often deepen this shame and stigma.

75. On top of these already isolating and devastating experiences, the Challenged Requirements act as a reminder to our patients that the State of Ohio believes that something about the care they are seeking is especially shameful or wrong.

VI. The Challenged Requirements Burden and Harm WMCD's Providers

76. The Challenged Requirements for abortion consistently and routinely interfere with my ability to provide the highest quality, trauma-informed[19] abortion care to my patients.

The laws create unnecessary conflict between what I am ethically required to do as a physician and what I am legally obligated to do as an abortion provider in the state of Ohio.

77. These laws, which stigmatize abortion care and treat it differently from early miscarriage care—and indeed any other kind of medical care—are not based in medical science or medical ethics and do not promote the best interests of the pregnant person. For example, it can be deeply upsetting as a provider to force my patient to remain pregnant, unable to access the miscarriage or abortion care they want and need, while grieving their desired pregnancy. I am the person who must send them away knowing the physical and emotional risks this delay poses to my patient. In other words, under Ohio's current abortion laws, I am not able to use my best medical judgment. I feel like I am trusted to be a doctor when I provide any other medical care, but not when I'm providing an abortion.

78. The mandated inclusion of stigmatizing barriers such as delayed care and the provision of irrelevant, and potentially distressing or misleading information prevents me from providing the best care possible to my patients. It impacts my ability to develop a trusting relationship and rapport with them, which is essential to the doctor-patient relationship; and forces me to act as a mouthpiece for the state. It often feels like the state has deliberately placed a wall between me and my patients, preventing me from providing the best medical advice and care possible.

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[19] Am. Med. Ass'n, *Adverse Childhood Experiences and Trauma-Informed Care*, Policy H-515.952 (2023), https://policysearch.ama-assn.org/policyfinder/detail/Adverse%20Childhood%20Experiences%20and%20Trauma-Informed%20Care%C2%A0%20H-515.952?uri=%2FAMADoc%2FHOD.xml-H-515.952.xml (last visited Mar. 26, 2024) (defining trauma-informed care as "a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization").

79. I am personally impacted by the emotional responses from patients whose care is delayed or who are forced through traumatic and unnecessary stigmatizing informed consent processes. Patients complain that they are being forced to wait and that they have to come back for another appointment. Patients tell me, you shouldn't make people wait this long; you shouldn't make us come back for so many appointments. Often, they assume I am to blame for this, because ultimately I am the person in front of them telling them that this is what they have to do–the professional they are relying upon to provide them care. I tell patients that if it was up to me, I woild provide them with the care they want today, because there is no medical reason not to do so. But then I have to explain that my hands are tied, and state law requires that they delay their desired care, and make additional sacrifices and suffer additional burdens in order to return to our clinic for another appointment. This absolutely creates obstacles to establishing trust with my patients and is devastating for me as a physician.

80. For all of these reasons, the challenged laws burden, penalize, prohibit, interfere with and discriminate against my ability to provide the highest level of quality abortion care to my patients, and against my patients seeking abortion care.

The undersigned hereby affirms that the statements made in the foregoing affidavit are true, under penalty of perjury.

Catharine Romanos, M.D.

Sworn to and subscribed before me this 28th day of March, 2024 in Franklin Co, Ohio.

Margaret A Light-Scotece No Exp.

MARGARET LIGHT-SCOTECE - NOTARY PUBLIC
My commission has not exp. date Sec. 147.03 O.R.C.
STATE OF OHIO

Notary Public