STATE OF MICHIGAN
IN THE 6TH JUDICIAL CIRCUIT COURT FOR THE COUNTY OF OAKLAND

GRETCHEN WHITMER, on behalf of the State of Michigan,

Plaintiff,

v

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

Defendants.

Oakland Circuit Court No. 22-193498-CZ

HON. JACOB J. CUNNINGHAM

GOVERNOR GRETCHEN WHITMER'S EMERGENCY MOTION FOR *EX PARTE* TEMPORARY RESTRAINING ORDER

This case involves a claim that state governmental action is invalid

GOVERNOR GRETCHEN WHITMER'S EMERGENCY MOTION FOR *EX PARTE* TEMPORARY RESTRAINING ORDER

The Plaintiff, Gretchen Whitmer, Governor of the State of Michigan, on behalf of the State of Michigan, brings this ex parte motion for a temporary restraining order pursuant to MCR 3.310(B). Governor Whitmer moves pursuant to MCR 3.310(B) for a temporary restraining order, without prior notice to the Defendants, because immediate and irreparable injury will result from any delay required to effect notice.

A temporary restraining order is necessary to prevent irreparable injury before the Court can consider Plaintiff's forthcoming motion for a preliminary injunction. Michiganders will suffer an irreparable injury if Defendants are permitted to enforce MCL 750.14, a near-total ban on abortion that violates the Michigan Constitution.

For these reasons, as set forth more fully in the brief in support of this motion, Plaintiff Governor Whitmer respectfully requests that the Court enter a temporary restraining order enjoining Defendants from enforcing MCL 750.14 until further Order of the Court.

Respectfully submitted,

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Dated: August 1, 2022

Attorneys for Governor Gretchen Whitmer

STATE OF MICHIGAN
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Defendants.

Oakland Circuit Court No. 22-193498-CZ

HON. JACOB J. CUNNINGHAM

GOVERNOR GRETCHEN WHITMER'S BRIEF IN SUPPORT OF EMERGENCY MOTION FOR *EX PARTE* TEMPORARY RESTRAINING ORDER

This case involves a claim that state governmental action is invalid

GOVERNOR WHITMER'S BRIEF IN SUPPORT OF MOTION FOR TEMPORARY RESTRAINING ORDER

On April 7, 2022, Governor Whitmer filed a Complaint in the 6th Judicial Circuit Court for the County of Oakland, seeking to protect Michiganders' constitutional right to obtain abortions and to strike down Michigan's criminal abortion statute, MCL 750.14. That same day, Planned Parenthood of Michigan and Dr. Sarah Wallet filed suit in the Michigan Court of Claims, seeking similar relief. On May 17, 2022, the Court of Claims preliminarily enjoined the Attorney General and all county prosecutors (including Defendants) from enforcing MCL 750.14, holding that it violated the Michigan Constitution's Due Process Clause.

Earlier today, the Michigan Court of Appeals issued an order holding that the injunction issued by the Court of Claims "does not apply to county prosecutors" because "jurisdiction of the Court of Claims does not extend to them." (Ex 1.) Importantly, that order did not question the Court of Claims' determination that MCL 750.14 was likely unconstitutional. However, several county prosecutors have publicly stated that they intend to enforce Michigan's criminal abortion statute, and the order by the Court of Appeals now clears a path for them to do so. Thus, because of the Court of Appeals' technical ruling regarding jurisdiction, healthcare providers in Michigan presently are forced to choose whether to continue offering healthcare services to women in this State or potentially face criminal prosecution, creating irreparable harm for women who need healthcare now.

Governor Whitmer now asks this Court to temporarily enjoin county prosecutors from enforcing the criminal abortion statute—a statute that the Court of Claims has already found to be likely unconstitutional.

STATEMENT OF FACTS AND PROCEEDINGS

MCL 750.14 Bans Nearly All Abortion In Michigan

MCL 750.14 was enacted in 1931 and has remained unchanged since that time. The statute makes it a felony for "[a]ny person" to "wilfully administer to any pregnant woman any medicine, drug, substance or thing whatever, or … employ any instrument or other means whatever, with intent thereby to procure the miscarriage of any such woman, unless the same shall have been necessary to preserve the life of such woman." Violations of this act are punishable by up to four years' imprisonment. MCL 750.503.

The Michigan Supreme Court has addressed the validity of MCL 750.14 in only two cases, both following the United States Supreme Court's decision in *Roe v Wade*. First, in *Bricker*, the Court construed the statute to avoid its then-patent unconstitutionality under the US Constitution. *People v Bricker*, 389 Mich 524 (1973). Specifically, the court held that, in light of *Roe*, MCL 750.14 did not apply to "abortions in the first trimester of a pregnancy as authorized by the pregnant woman's attending physician in [the] exercise of his medical judgment." *Id.* at 527. And it held that MCL 750.14 did not apply to abortions after viability "where necessary" in the physician's "medical judgment to preserve the life or health of the mother." *Id.* at 530. But, the Court said, the statute could criminalize abortions performed by anyone other than licensed physicians even under *Roe*. *Id.* at 531. Second, in *Larkin*, the Court explained, "[b]y reason of *Roe v Wade*, we are compelled to rule that as a matter of federal constitutional law, a fetus is

conclusively presumed not to be viable within the first trimester of pregnancy." *Larkin v Calahan*, 389 Mich 533, 542 (1973).

Thus, from 1973 until today, all abortions in the first trimester and abortions necessary to preserve the life or health of the mother have been legal in Michigan.

Abortion In Michigan Today

Abortion is a common, safe, and medically necessary procedure. In the United States, approximately one in four women will have an abortion by age 45. Rachel K Jones and Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States*, 2008–2014, 107 Am J Pub Health 1904, 1907 (Dec 2017). In 2020, a total of 29,669 induced abortions were reported in Michigan.[1]

Complications arising from abortions are rare. Abortion does not present any long-term health risks, and does not increase a woman's risk of infertility, pre-term delivery, breast cancer, or mental health disorders. National Academies of Sciences, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States*, pp 9–10 (2018). The Michigan Department of Health and Human Services (DHHS) has acknowledged that the vast majority of abortions induced in the state contain no immediate complications. Of the 29,669 abortions induced in 2020, just seven immediate complications were reported. DHHS reports that the average three-year rate of complications between 2017 and 2019 was 3.5 per 10,000

[1] Michigan Dep't of Health & Human Servs, Induced Abortions in Michigan: January 1 through December 31, 2020 (June 2021), https://www.mdch.state.mi.us/osr/abortion/Tab_A.asp.

induced abortions: just 0.035%. Michigan Dep't of Health & Human Servs, Induced Abortions, at p 2. Complications arising from abortion are much less frequent than complications arising during childbirth. National Academies, *supra*, at p 11. The risk of death after a legal abortion is just a fraction of the risk of death from childbirth (0.7 per 100,000 compared to 8.8 per 100,000). *Id.* at pp 74–75. Abortion-related mortality is also lower than that for colonoscopies, plastic surgery, and adult tonsillectomies. National Academies at pp 74–75.

Michigan women decide to end pregnancies for a variety of reasons. Some decide that it is not the right time to have a child or to grow their families. Some end pregnancies because of a severe fetal anomaly, or because they have become pregnant as a result of rape or incest. Some choose not to have biological children, and some end a pregnancy because they cannot financially support a child, or because continuing with a pregnancy could pose a significant risk to their health.

The Criminal Abortion Ban's Effect On Michigan Women

If allowed to go into effect in full, MCL 750.14 would make it impossible for Michiganders to access legal abortion care within Michigan, except in the narrowest of circumstances. Providers will cease providing abortion care in Michigan out of fear of criminal prosecution, imprisonment, and loss of their medical licenses. Michigan's criminal abortion ban therefore effectively eliminates the ability of women to obtain safe and legal abortions in Michigan.

This ban harms Michigan women. For the many women who will be unable to access abortion in Michigan, travel to another state may not be an option due to

time and expense constraints. This is particularly true for those in low-income communities, who make up the majority of patients seeking abortions. *See* Natl. Academies of Sciences, Eng. & Medicine, *The Safety and Quality of Abortion Care in the United States*, 6 (2018) (finding that 75 percent of women who obtain abortion care are "poor or low income"). Patients in these communities are more likely to be subjected to delays in seeking medical care because of associated costs.[2] Those who are able to travel to another state will incur significant costs.[3] They may have to book plane tickets, rent a car, pay for hundreds of miles worth of gas, and book a hotel room—possibly for multiple nights. Many will have to take a day or multiple days off from work, which may be especially difficult for those without paid time off. And those women who are already parents may have to arrange for childcare.[4] For many Michigan women seeking healthcare, travel to another state may not be an option due to time and expense constraints.

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[2] Bd of Governors of the Fed Res Sys, *Report on the Economic Well-Being of US Households in 2021* (May 2022), https://www.federalreserve.gov/publications/2022-economic-well-being-of-ushouseholds-in-2021-dealing-with-unexpected-expenses.htm (finding that 38 percent of people with family incomes of less than $25,000 went without some medical care because they couldn't afford it).

[3] Dhanova & Lalijee, *Gas, food, and a hotel: Americans seeking an abortion out of state already shell out up to $10,000 for the procedure. Experts warn that cost could rise.* Insider (June 24, 2022), https://www.businessinsider.com/abortion-costs-roe-v-wade-out-of-state-supreme-court-2022-5; Karen Brooks Harper, *Wealth will now largely determine which Texans can access abortion*, The Texas Tribune (June 24, 2022), https://www.texastribune.org/2022/06/24/texas-abortion-costs.

[4] Margot Sanger Katz, Claire Cain Miller, and Quoctrung Bui, *Who Gets Abortions in America?*, The New York Times (Dec. 14, 2021).

Those unable to obtain care out of state will be forced to either carry to term and give birth against their will—incurring irreparable physical, economic, emotional, and psychological harms—or resort to potentially unsafe methods of abortion.[5] Reducing or eliminating access to legal abortion will increase pregnancy-related deaths.[6] One study found that the risk of death associated with childbirth is approximately fourteen times higher than that with abortion.[7] These consequences will be disproportionately felt by communities of color. In 2020, 52.9% of Michiganders who obtained abortions were Black, while the Black community represented only 12.4% of Michigan's population. And the maternal mortality rate in Michigan is significantly higher for Black women: Black women are 2.8 times more likely to die from pregnancy-related causes than white women.

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[5] Natl Inst of Child Health & Human Dev, *What Are Some Common Complications of Pregnancy?*, https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/complications (identifying as "common complications of pregnancy" high blood pressure, gestational diabetes, infections, preeclampsia, preterm labor, depression and anxiety, pregnancy loss or miscarriage, and stillbirth); Laurie Zephyrin, So O'Neil, and Kara Zivin, *The staggering toll of complications related to pregnancy and childbirth*, STAT (Nov 23, 2021), https://www.statnews.com/2021/11/23/staggering-toll-pregnancy-childbirth-related-complications; *Severe Maternal Morbidity in the United States*, Centers for Disease Control and Prevention, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html.

[6] See Stevenson, *The Pregnancy-Related Morality Impact of a Total Abortion Ban in the United States: A Research Note on Increased Deaths Due to Remaining Pregnant*, Demography (2021).

[7] Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215 (Feb 2012).

Women forced to carry pregnancies to term will also lose educational opportunities, face decreased opportunities to advance their careers, and are more likely to experience economic insecurity and raise their children in poverty. See Diana Green Foster, Ph.D, *The Turnaway Study: The Cost of Denying Women Access to Abortion* (2020) (examining the physical, mental, and socioeconomic consequences of receiving an abortion compared to carrying an unwanted pregnancy to term). Women who are denied abortions face a "large and persistent . . . increase in financial distress" following the denial of care. They experience more past-due debt and are more likely to experience bankruptcy and eviction. See Miller, Wherry, Greene Foster, *The Economic Consequences of Being Denied an Abortion*, National Bureau of Economic Research (Working Paper 26662 Jan 2022) p 36. They may also face increased pressure to stay in contact with violent or abusive partners, which puts both women and children at risk.

Absent action from this court, MCL 750.14 will inflict serious and irreparable harm on pregnant women in Michigan.

Procedural History

On April 7, 2022, the Governor filed a Complaint for Declaratory and Injunctive Relief in the 6th Judicial Circuit Court for the County of Oakland, raising claims for declaratory and injunctive relief under the Michigan Constitution. Simultaneously, the Governor sent an executive message addressed to the Michigan Supreme Court, asking that Court to authorize this Court to certify the questions

raised by the Complaint to the Michigan Supreme Court for immediate consideration.

That same day, Planned Parenthood of Michigan and Dr. Sarah Wallet filed suit in the Michigan Court of Claims, seeking a declaration that MCL 750.14 is unconstitutional under the Michigan Constitution and requesting preliminary and permanent injunctions barring its enforcement. On May 17, 2022, the Court of Claims preliminarily enjoined MCL 750.14, finding a substantial likelihood that the statute violates the Due Process Clause of the Michigan Constitution. Opinion and Order, *Planned Parenthood of Michigan, et al v Attorney General of the State of Michigan*, Case No 22-000044-MM (Mich Ct Claims May 17, 2022) (*Planned Parenthood* Op).

On June 24, 2022, the U.S. Supreme Court overruled *Roe v Wade*, 410 US 113 (1973) and *Planned Parenthood of Southeastern Pa v Casey*, 505 US 833 (1992). *See* Slip Op. at 5, *Dobbs v Jackson Women's Health Org*, No. 19-1392.

On August 1, 2022, the Court of Appeals issued an order in the Planned Parenthood case dismissing a complaint for superintending control by two local prosecutors, Jerard Jarzynka and Christopher R. Becker, and two non-profit organizations. Order, *In re Jarzynka*, No. 361470 (Mich Ct App Aug 1, 2022). In reaching this decision, the Court of Appeals noted that "[b]ecause county prosecutors are local officials, jurisdiction of the Court of Claims does not extend to them." *Id.* at 3. The Court of Appeals also explained that "plaintiffs Jarzynka and Becker are not and could not be bound by the Court of Claims' May 17, 2022

preliminary injunction because the preliminary injunction does not apply to county prosecutors." *Id.* at 5. The Court of Appeals did not otherwise disturb the decision of the Court of Appeals, which concluded that Michigan's criminal abortion statute likely violates the Michigan Constitution.

STANDARD FOR INJUNCTIVE RELIEF

This Court should provide injunctive relief because the factors governing injunction relief, including a temporary restraining order are met: (1) Plaintiff is likely to prevail on the merits; (2) Plaintiff will suffer irreparable harm if a TRO is not issued; (3) the public interest will be harmed if a TRO is not granted; and (4) the injury that Defendant will suffer if a TRO is issued does not outweigh the harm that the Plaintiff would suffer if preliminary injunctive relief is not granted. *Detroit Fire Fighters Ass'n IAFF Local 344 v City of Detroit Fire Fighters*, 482 Mich 18, 34 (2008), citing *Michigan State Employees Ass'n v Dep't of Mental Health*, 421 Mich 152, 157–158 (1984). See also *Davies v Treasury Dep't*, 199 Mich App 437, 439 (1993). The second, third, and fourth factors are largely supported by the same facts and will be addressed together.

ARGUMENT

I. Michigan citizens will suffer irreparable harm without a temporary restraining order, and the exigencies of this case warrant an ex parte order.

Given the severity of the irreparable harm for women in Michigan, the Governor will first address the three elements regarding harm to the parties. The TRO should issue to avoid irreparable harm to Michigan women and abortion providers, which is strongly in the public interest, and any alleged harm to the defendants is minimal, at best.

A. Both abortion providers and those seeking abortion access in Michigan will suffer irreparable harm.

Irreparable harm is "evaluated in light of the totality of the circumstances affecting, and the alternatives available to," the party seeking injunctive relief. *State Employees Ass'n v Dep't of Mental Health*, 421 Mich 152, 166–167 (1984). But "if it is found that a constitutional right is being threatened or impaired, a finding of irreparable injury is mandated." *Am Civil Liberties Union of Ky v McCreary County*, 354 F3d 438, 445 (CA 6, 2003), citing *Elrod v Burns*, 427 US 347, 373 (1976) (holding that in an area of fundamental constitutional rights, the loss of constitutional rights "for even minimal periods of time[ ] unquestionably constitutes irreparable injury"); *Garner v Mich State Univ*, 185 Mich App 750, (1990) ("[T]emporary loss of a constitutional right constitutes irreparable harm which cannot be adequately remedied by an action at law.") (citation omitted).

On August 1, 2022, the Court of Appeals ruled in *In re Jarzynka* that the Court of Claims injunction does not bind the prosecutors because they are not proper parties in the Court of Claims. (Mich Ct App Order (Docket No. 361470), p 3 ("[W]e conclude that, under the totality of the circumstances, the core nature of a county prosecutor is that of a local, not a state official. Because county prosecutors are local officials, jurisdiction of the Court of Claims does not extend to them."). Thus, the Court stated, "We conclude that on the facts before this Court, plaintiffs Jarzynka and Becker are not and could not be bound by the Court of Claims' May 17, 2022 preliminary injunction because the preliminary injunction does not apply to county prosecutors." (Order, p 5.) As noted, the Court did not disrupt the Court of Claims' determination that enforcement of the law by the Attorney General should be enjoined, including the court's ruling that the law is likely unconstitutional and that irreparable harm would flow from the absence of an injunction.

In light of the Court of Appeals order, there will be immediate and irreparable harm to both abortion providers and those seeking abortions in Michigan absent a temporary restraining order in this case. Under MCL 750.14, providers can face potential prosecution and investigation for providing constitutionally protected abortions. The threat of investigation and prosecution will chill providers from providing this medical care, and consequently, result in the inability of pregnant persons to access abortions in Michigan.

And this harm is not speculative. *First*, the threat of investigation and prosecution is real. Several Defendants have publicly pledged to enforce the criminal abortion statute, *even before the Court of Appeals held they were not bound by the injunction*. After the U.S. Supreme Court opinion in *Dobbs*, Defendant Kent County Prosecutor Becker stated, "I'm not going to say yes (to prosecution) for sure, because every case is dependent on the facts that are brought in. . . . But I think the clearest thing I can say is, I'm not ignoring this law. It's a validly passed statute. I'm not ignoring it, and we'll go from there." Bridge Michigan, "Abortion providers may face charges in Kent, Jackson counties, attorney says," June 27, 2022.[8] As reported, Defendant Jackson County Prosecutor Jarzynka pledged to prosecute the provision of abortion services like any other criminal law:

> "There is a statute on the books that basically prohibits abortion except for the life of the mother," Jarzynka said, referring to the provision in the law that states an abortion can take place if the pregnant person's life is in danger. "That's the law right now, and as a prosecutor I'm going to follow the law. Basically, if the police or law enforcement agency brings me a case. . . . I will look at it as I will any other criminal violation that's alleged," Jarzynka continued. "As a prosecutor, I can't ignore the law."[9]

See also *The Detroit News*, "Will Michigan's Top County Prosecutors Enforce an Abortion Ban?" May 3, 2022 (Defendant Macomb County Prosecutor Peter Lucido stating prosecutors don't have the "right to pick and choose laws in this state" and "If the police present a valid warrant with those elements of a crime, a

[8] See https://www.bridgemi.com/michigan-government/abortion-providers-may-face-charges-kent-jackson-counties-attorney-says

[9] See https://www.wilx.com/2022/06/29/jackson-county-prosecutor-says-hell-consider-criminal-charges-abortion-providers-michigan/

prosecutor must prosecute.") And Defendant Macomb County Prosecutor Peter Lucido has asserted that he has "a legal duty to uphold the laws of this state until or unless they are repealed or a court order me not to."[10]

Other Defendants who have not publicly pledged to enforce the abortion statute like any other law now will have free rein to do so after the Court of Appeals ruling takes effect. Defendants now have reason to believe they are not bound by a valid injunction—their threats must be taken seriously and their public statements may already causing abortion providers to cease providing abortion services. Thus, the threat of criminal investigation and prosecution by Defendants is both real and imminent.

Second, the chilling effect on providers and the loss of abortion access for pregnant persons is well-documented. As it relates to abortion providers, DHHS Chief Medical Executive Dr. Natasha Bagdasarian explained that although physicians have a duty to provide their patients with treatment consistent with the medical standard of care, threatened enforcement of MCL 750.14 may not permit doctors to do so as they will be forced to risk incurring criminal and civil liability in the process. (Ex 2, Affidavit of Dr. Bagdasarian, ¶ 13.) Dr. Sarah Wallett, the Chief Medical Officer of Planned Parenthood of Michigan and a board-certified obstetrician-gynecologist licensed in Michigan, has also testified that if the criminal abortion ban is enforced, abortion providers "would be forced to stop providing

[10] https://www.macombdaily.com/2022/04/08/lucido-says-macomb-county-has-legal-duty-to-prosecute-abortion-center-complaints/

abortion under virtually any circumstance—that, or face felony prosecution and licensure penalties." (Ex 3, Affidavit of Dr. Wallett, ¶ 75.)

She further explained that "[i]f abortion were unavailable in Michigan, many people would not be able to travel to another state to access abortion, or would be significantly delayed by the cost and logistical arrangement required to do so." (*Id.*, ¶ 76.)

This delay or lack of access to abortion services will also negatively affect pregnant persons across the State. Indeed, Dr. Bagdasarian explained that time is of the essence as it relates to several circumstances impacted by Michigan's criminal abortion ban. (Affidavit of Dr. Bagdasarian, ¶ 7.) In particular, ectopic pregnancies, nonviable pregnancies, pregnancies resulting in miscarriage, and pregnancies that present a risk to the health of the mother all can present situations in which access to abortions is necessary and the timing of these abortions is critical. (*Id.*, ¶¶ 7–9.) Confusion regarding the legality of abortions or a physician's inability to provide an abortion could negatively impact the health of the woman and increase the risk of death. (*Id.*, ¶ 7.) In light of these medical realities, even a 14-day delay can result in a pregnant person needing to use a more dangerous procedure or foreclose the possibility of being able to have the procedure. These circumstances demonstrate both the irreparable and imminent injuries that will occur absent an injunction.

B. An ex parte temporary restraining order is appropriate under the exigent circumstances of this case.

The exigencies of this case also warrant an ex parte order under MCR 3.310(B)(1)(a). The threatened enforcement of MCL 750.14 is causing, and will continue to cause, immediate and irreparable injury, loss, and damage. As explained above, the need for abortion services is inherently a time-sensitive need.

MCL 750.14 imposes a complete ban on all abortions except for very narrow life-threatening circumstances. In light of today's order from the Michigan Court of Appeals in *Planned Parenthood of Michigan v Nessel*, providers may refuse to provide abortion care *today*, and will continue to refuse care due to the threat of criminal prosecution until an order is in place enjoining those prosecutions. Even in situations in which the life of the pregnant woman is in danger, and in which an abortion would be nominally lawful under the text of the statute, the threat of criminal prosecution casts a chill over important medical decisions that should be between an individual and her doctor, not between an individual, her doctor, and the criminal enforcement authority of the State of Michigan.

This Court may provide temporary injunctive relief without Plaintiff first providing notice to defendants if:

> (a) it clearly appears from specific facts shown by affidavit or by a verified complaint that immediate and irreparable injury, loss, or damage will result to the applicant from the delay required to effect notice or from the risk that notice will itself precipitate adverse action before an order can be issued;
>
> (b) the applicant's attorney certifies to the court in writing the efforts, if any, that have been made to give the notice and the reasons supporting the claim that notice should not be required; and

> (c) a permanent record or memorandum is made of any nonwritten evidence, argument, or other representations made in support of the application. [MCR 3.310(B)(1).]

In this case, Defendants will not suffer any irreparable injury from being temporarily unable to enforce MCL 750.14 – the status quo yesterday and for almost 50 years before that. And the Governor is not asking for an injunction before bringing an action. To the contrary, she filed her complaint almost four months ago, and all defendants are on notice as to the legal arguments advanced in this case. There is no prejudice to Defendants from this Court entering a temporary restraining order to preserve the status quo and quell any confusion or chilling of rights while this Court may consider whether to issue a preliminary injunction in due course.

II. Governor Whitmer Will Prevail On the Merits In Showing MCL 750.14 Is Unconstitutional

The Court of Claims' decision was correct that Michigan's criminal abortion statute violates the right to bodily integrity protected by Michigan's Due Process Clause, and nothing in the Court of Appeals' decision undermines that holding.

The Court of Claims granted a preliminary injunction in the Planned Parenthood case based on a finding that there was a "strong likelihood that plaintiffs will prevail on the merits of their constitutional challenge" to Michigan's criminal abortion statue. *Planned Parenthood* Op 25. In reaching that decision, the Court of Claims explained that it was "not constrained to adopt the United States' Supreme Court's analysis of the constitutionality of abortion under the United States Constitution but must instead focus its inquiry on the rights and guarantees

conferred by *our* Constitution." *Id.* at 15. And under the Michigan Constitution, the Court of Claims found that "the right to bodily integrity is indisputably fundamental" and protected by the Due Process Clause. *Id.* at 20. The Court of Claims also found that, based on the physical and psychological impacts of even a healthy pregnancy on women, "the link between the right to bodily integrity and the decision whether to bear a child is an obvious one." *Id.* at 20. The Court concluded, "Forced pregnancy, and the concomitant compulsion to endure medical and psychological risks accompanying it, contravene the right to make autonomous medical decisions. If a woman's right to bodily integrity is to have any real meaning, it must incorporate her right to make decisions about the health events most likely to change the course of her life: pregnancy and childbirth." *Id.* at 22–23. Accordingly, the Court of Claims concluded that there was a "substantial likelihood that [] MCL 750.14 violates the Due Process Clause of Michigan's Constitution." *Id.* at 25.

MCL 750.14 is also constitutionally deficient in other ways.

First, MCL 750.14 violates the right to privacy, which is also protected by the Due Process Clause. The Michigan Supreme Court has recognized the right to privacy as "a highly valued right" since 1881. *See Advisory Opinion on Constitutionality of 1975 PA 227 (Questions 2-10)*, 396 Mich 465, 504 (Mich 1976) (citing *De May v Roberts*, 46 Mich 160 (1881)). The right to procreate—and to choose not to—are critical components of the right to privacy in making intimate familial decisions because "decisions whether to accomplish or to prevent conception

are among the most private and sensitive" anyone can make. *Carey v Population Servs, Int'l*, 431 US 678, 685 (1977).

Second, MCL 750.14 violates the Michigan Equal Protection Clause. The historical context leading to the enactment of MCL 750.14 demonstrates that it was enacted for discriminatory purposes—to police women's compliance with restrictive gender norms and thereby ensure their inferior status in society—and not for any legitimate government purpose. *See* Mohr, *Abortion in America: The Origins and Evolution of National Policy, 1800–1900* pp 46–47, 86–88, 90, 105, 117–118 (1978). By enforcing outdated gender stereotypes and requiring women to become parents against their will, MCL 750.14 infringes on the right to equal protection under the law as guaranteed in the Michigan Constitution. In addition, because the pursuit of equality underlies the privacy and liberty interests in reproductive choice, art 1, § 2 provides a basis for the right to choose an abortion in Michigan.

CONCLUSION AND RELIEF REQUESTED

MCL 750.14 violates the Michigan Constitution, and the threat of prosecutions under it causes irreparable harm to Michiganders' constitutional rights and their health. A temporary restraining order to enjoin Defendants from enforcing MCL 750.14 is necessary.

For these reasons, Plaintiffs seek an immediate order from this Court that prohibits Defendants from enforcing MCL 750.14.

Respectfully submitted,

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Dated: August 1, 2022

Attorneys for Governor Gretchen Whitmer

STATE OF MICHIGAN
IN THE 6TH JUDICIAL CIRCUIT COURT FOR THE COUNTY OF OAKLAND

GRETCHEN WHITMER, on behalf of the State of Michigan, Plaintiff, v JAMES R. LINDERMAN, Prosecuting Attorney of Emmet County, et al., Defendants.	Case No. 22-193498-CZ HON. JACOB JAMES CUNNINGHAM

INDEX OF EXHIBITS TO GOVERNOR GRETCHEN WHITMER'S BRIEF IN SUPPORT OF EMERGENCY MOTION FOR EX PARTE TEMPORARY RESTRAINING ORDER

Exhibit 1 - In re Jarzynka opinion.

Exhibit 2 - Affidavit of Dr. Bagdasarian

Exhibit 3 – Affidavit of Wallett

Court of Appeals, State of Michigan

ORDER

In re Jarzynka

Docket No. 361470

LC No. 22-000044-MM

Stephen L. Borrello
Presiding Judge

Michael J. Kelly

Michael F. Gadola
Judges

The complaint for superintending control is DISMISSED because plaintiffs Jerard M. Jarzynka, Christopher R. Becker, Right to Life of Michigan, and the Michigan Catholic Conference lack standing to seek superintending control.

Plaintiffs seek superintending control over Court of Claims Judge Elizabeth L. Gleicher. Their complaint relates to Court of Claims Case No. 22-000044-MM, *Planned Parenthood of Mich v Mich Attorney General*. The parties to the Court of Claims action are Planned Parenthood of Michigan and Dr. Sarah Wallett (the plaintiffs); the Attorney General of the State of Michigan (the defendant); and the Michigan House of Representatives and the Michigan Senate (collectively, the Legislature) (the intervening parties). On May 17, 2022, Judge Gleicher entered a preliminary injunction in the Court of Claims case which, in relevant part, purported to enjoin Michigan county prosecutors from enforcing MCL 750.14.[1]

We invited the parties to this action to submit supplemental briefs addressing whether dismissal for lack of jurisdiction was warranted under MCR 3.302. *In re Jarzynka*, unpublished order of the Court of Appeals, entered June 27, 2022 (Docket No. 361470). Having received supplemental briefs from plaintiffs and from Planned Parenthood of Michigan (who filed an appearance as an other party in this action), we conclude that dismissal for lack of jurisdiction is not warranted. "Superintending control is an extraordinary remedy, and extraordinary circumstances must be presented to convince a court that the remedy is warranted." *In re Wayne Co Prosecutor*, 232 Mich App 482, 484; 591 NW2d 359 (1998). "Superintending control is available only where *the party seeking the order* does not have another adequate remedy." *In re Payne*, 444 Mich 679, 687; 514 NW2d 121 (1994) (emphasis added), citing MCR 3.302(B). An appeal available to the party seeking an order of superintending control is "another adequate remedy" that is available to the party seeking the order , and it requires denial of the request. MCR 3.302(D)(2); *In re Payne*, 444 Mich at 687.

An appeal of the Court of Claims' order is not available to either Right to Life of Michigan or the Michigan Catholic Conference, neither of whom were parties to the Court of Claims' action.

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[1] MCL 750.14 prohibits any person from administering any drug or substance or utilizing any instrument to procure a miscarriage unless necessary to preserve a woman's life.

Therefore, dismissal of their complaint for superintending control is not mandated under MCR 3.302(D)(2).

As it relates to Jarzynka and Becker, Planned Parenthood of Michigan argues that they are state officials subject to the jurisdiction of the Court of Claims. As a result, they contend that, like the Legislature, Jarzynka and Becker could have intervened in the Court of Claims action and, subsequently, could have appealed the Court of Claims' decision. County prosecuting attorneys, however, are local officials, not state officials.

"The Court of Claims is a court of legislative creation" designed to "hear claims against the state." *Council of Organizations & Others for Ed About Parochiaid v State of Michigan*, 321 Mich App 456, 466-467; 909 NW2d 449 (2017) (quotation marks and citation omitted). MCL 600.6419(1)(a) grants the Court of Claims jurisdiction:

> To hear and determine any claim or demand, statutory or constitutional . . . or any demand for monetary, equitable, or declaratory relief . . . against the state or any of its departments or officers notwithstanding another law that confers jurisdiction of the case in the circuit court.

In relevant part, MCL 600.6419(7) defines "the state or any of its departments or officers" to include "an officer . . . of this state . . . acting, or who reasonably believes that he or she is acting, within the scope of his or her authority while engaged in or discharging a governmental function in the course of his or her duties." Our Supreme Court has determined that county prosecutors are "clearly local officials elected locally and paid by the local government." *Hanselman v Killeen*, 419 Mich 168, 188; 351 NW2d 544 (1984). Moreover, our Supreme Court has stated that a reviewing court should consider the following four factors to determine if an entity is a state agency that is subject to the jurisdiction of the Court of Claims:

> (1) whether the entity was created by the state constitution, a state statute, or state agency action, (2) whether and to what extent the state government funds the entity, (3) whether and to what extent a state agency or official controls the actions of the entity at issue, and (4) whether and to what extent the entity serves local purposes or state purposes. [*Manuel v Gill*, 481 Mich 637, 653; 753 NW2d 48 (2008).]

The test requires an examination of the "totality of the circumstances" to determine "the core nature of an entity" so as to ascertain "whether it is predominantly state or predominantly local." *Id*. at 653-654. We adopt this test in order to determine whether a county prosecutor is a state official under MCL 600.6419(7).

First, the office of a county prosecutor was created by our State Constitution. Michigan's 1963 Constitution addresses county prosecutors in Article VII, which governs "Local Government." Const 1963, art 7, § 4 provides:

> There shall be elected for four-year terms in each organized county a sheriff, a county clerk, a county treasurer, a register of deeds and a prosecuting attorney, whose duties and powers shall be provided by law.

Further, the general duties of county prosecutors are set forth by statute. MCL 49.153 provides that:

> The prosecuting attorneys shall, *in their respective counties*, appear for the state or county, and prosecute or defend in all the courts of the county, all prosecutions, suits, applications and motions whether civil or criminal, in which the state or county may be a party or interested. [Emphasis added.]

While MCL 49.153 states that county prosecutors "shall appear for the state," their authority is explicitly limited to "their respective counties." We conclude that because our state constitution addresses county prosecutors as part of local government and because their authority is limited to their respective counties, the first *Manuel* factor cuts against a finding that county prosecutors are state officials. See *Manuel*, 481 Mich at 653.The next inquiry is "whether and to what extent the state government funds the entity." *Manuel*, 481 Mich at 653. As recognized in *Hanselman*, 419 Mich at 189, county prosecutors are generally locally funded. Indeed, MCL 49.159(1) provides that "[t]he prosecuting attorney shall receive compensation for his or her services, as the county board of commissioners, by an annual salary or otherwise, orders and directs." Accordingly, this factor weighs in favor of a determination that county prosecutors are local, not state officials.

The next inquiry is "whether and to what extent a state agency or official controls the actions of the entity at issue." *Manuel*, 481 Mich at 653. This Court has recognized that the Attorney General has supervisory authority over local prosecutors. See *Shirvell v Dep't of Attorney Gen*, 308 Mich App 702, 751; 866 NW2d 478 (2015), citing MCL 14.30. MCL 14.30 provides that "[t]he attorney general shall supervise the work of, consult and advise the prosecuting attorneys, in all matters pertaining to the duties of their offices." Yet, despite the Attorney General's supervisory authority, county prosecutors retain substantial discretion in how to carry out their duties under MCL 49.153. See *Fieger v Cox*, 274 Mich App 449, 466; 734 NW2d 602 (2007) ("Pursuant to MCL 49.153, prosecuting attorneys in Michigan possess broad discretion to investigate criminal wrongdoing, determine which applicable charges a defendant should face, and initiate and conduct criminal proceedings."). Because county prosecutors have substantial discretion to carry out their duties to prosecute and defend cases in their respective counties, the fact that the Attorney General has supervisory authority does not transform what is otherwise a local official into a state official.

The final inquiry is "whether and to what extent the entity serves local purposes or state purposes." *Manuel*, 481 Mich at 653. Taking all of the above into consideration, a county prosecutor represents the state in criminal matters (and in child protective proceedings),[2] but their authority only extends to matters in their respective counties and they exercise independent discretion in carrying out those duties. Stated differently, notwithstanding that county prosecutors represent the State of Michigan, they serve primarily local purposes involving the enforcement of state law within their respective counties.

In light of the four-part inquiry from *Manuel*, we conclude that, under the totality of the circumstances, the core nature of a county prosecutor is that of a local, not a state official. Because county prosecutors are local officials, jurisdiction of the Court of Claims does not extend to them. See *Mays v*

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[2] See *Messenger v Ingham Co Prosecutor*, 232 Mich App 633, 640; 591 NW2d 393 (1998) (stating that county prosecutors act "as the state's agent for effectuation of the obligations of *parens patriae* in matters concerning the custody or welfare of children . . . .").

Snyder, 323 Mich App 1, 47; 916 NW2d 227 (2018) ("The jurisdiction of the Court of Claims does not extend to local officials."). As a result, plaintiffs Jarzynka and Becker could not intervene in the Court of Claims action and an appeal of the Court of Claims' decision was not available to them. Dismissal of the county prosecutors is, therefore, not warranted under MCR 3.302(D)(2).

We next consider whether the availability of an appeal by a party other than the party seeking superintending control is sufficient to deprive this Court of jurisdiction under MCR 3.302(D)(2). We conclude that, under the circumstances of this case, it is not. First, as the defendant in the Court of Claims action, the Attorney General could have appealed the decision enjoining it from enforcing MCL 750.14. The Attorney General, however, declined to do so. Second, as the Michigan House of Representatives and the Michigan Senate are intervening parties in the Court of Claims action, an appeal of that decision was available to them. They have, in fact, filed an application for leave to appeal the decision of the Court of Claims. However, that application remains pending, and there is no guarantee that leave to appeal will be granted or will otherwise be decided on the merits. We conclude that, under the facts of this case, the possibility that the decision by the Court of Claims *may* be challenged in an appeal brought by an individual or entity other than the one seeking superintending control is not the equivalent of "another adequate remedy *available to the party seeking the order*" of superintending control. MCR 3.302(B) (emphasis added). As a result, dismissal of the complaint for superintending control is not warranted based on the fact that an appeal is available to the Attorney General or to the Legislature.

Having determined that the complaint for superintending control does not fail for want of jurisdiction under MCR 3.302, we next turn to whether plaintiffs' complaint for superintending control must be dismissed for lack of standing. It is well-established that "a party seeking an order for superintending control must still have standing to bring the action." *Beer v City of Fraser Civil Serv Comm*, 127 Mich App 239, 243; 338 NW2d 197 (1983). "Standing is the legal term to be used to denote the existence of a party's interest in the outcome of a litigation; an interest that will assure sincere and vigorous advocacy." *Id*. "A party lacks standing to bring a complaint for superintending control where plaintiff has shown no facts whereby it was injured." *Id*. Here, as a legal cause of action is not provided to plaintiffs at law, this Court must determine whether plaintiffs have standing. See *Lansing Sch Ed Ass'n v Lansing Bd of Ed*, 487 Mich 349, 372; 792 NW2d 686 (2010). Under such circumstances, "[a] litigant may have standing . . . if the litigant has a special injury or right, or substantial interest, that will be detrimentally affected in a manner different from the citizenry at large . . . ." *Id*.

Plaintiffs Jarzynka and Becker contend that they have standing because the Court of Claims' preliminary injunction purports to bind them. The preliminary injunction provides in relevant part:

> (1) Defendant [i.e., the Attorney General] and anyone acting under defendant's control and supervision, see MCL 14.30, are hereby enjoined during the pendency of this action from enforcing MCL 750.14;
>
> (2) Defendant shall give immediate notice of this preliminary injunction to all state and local officials acting under defendant's supervision that they are enjoined and restrained from enforcing MCL 750.14[.]

Although the injunction purports to enjoin anyone acting under the Attorney General's control and supervision, MCL 14.30 does not give the Attorney General "control" over county prosecutors. Rather, it provides that "[t]he attorney general shall supervise the work of, consult and advise the prosecuting attorneys, in all matters pertaining to the duties of their offices." Thus, although the Attorney General may supervise, consult, and advise county prosecutors, MCL 14.30 does not give the Attorney General the general authority to control the discretion afforded to county prosecutors in the exercise of their statutory duties.[3]

Moreover, under MCR 3.310(C)(4), an order granting an injunction "is binding only on the parties to the action, their officers, agents, servants, employees, and attorneys, and on those persons in active concert or participation with them who receive actual notice of the order by personal service or otherwise." As recognized by Planned Parenthood of Michigan in a footnote in their supplemental brief filed on July 1, 2022, in this action, plaintiffs Jarzynka and Becker are not parties to the action before the Court of Claims. Further, as local officials, they could not be parties to the Court of Claims action. See *Mays*, 323 Mich App at 47. Nor are they the officers, agents, servants, employees, or attorneys of the parties, i.e., the Attorney General, Planned Parenthood of Michigan, or Dr. Wallett. Additionally, they are not "in active concert or participation" with those parties given that the Attorney General, Planned Parenthood, and Dr. Wallett appear to agree that MCL 750.14 should not be enforced.

We conclude that on the facts before this Court, plaintiffs Jarzynka and Becker are not and could not be bound by the Court of Claims' May 17, 2022 preliminary injunction because the preliminary injunction does not apply to county prosecutors. As a result, Jarzynka and Becker cannot show that they were injured by the issuance of the preliminary injunction. See *Beer*, 127 Mich App at 243, or that they have "a special injury or right, or substantial interest, that will be detrimentally affected in a manner different from the citizenry at large," *Lansing Sch Ed Ass'n*, 487 Mich at 372. And, because they lack standing, their complaint for superintending control must be dismissed.

Plaintiffs Right to Life of Michigan and the Michigan Catholic Conference also lack standing. Although they do not favor the preliminary injunction, they have not suffered any injury as a result of it, *Beer*, 127 Mich App at 243, nor have they shown the existence of "a special injury or right, or substantial interest, that will be detrimentally affected in a manner different from the citizenry at large,"

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[3] Although MCL 14.30 does not give the Attorney General the ability to control county prosecutors, other statutory provisions give the Attorney General limited control over county prosecutors. For example, MCL 49.160(2), provides that the Attorney General may determine that a county prosecutor is "disqualified or otherwise unable to serve." Under such circumstances, the Attorney General "may elect to proceed in the matter or may appoint a prosecuting attorney or assistant prosecuting attorney who consents to the appointment to act as a special prosecuting attorney to perform the duties of the prosecuting attorney in any matter in which the prosecuting attorney is disqualified or until the prosecuting attorney is able to serve." Even that "control" over the prosecuting attorney, however, is limited. MCL 49.160(4) expressly provides that "[t]his section does not apply if an assistant prosecuting attorney has been or can be appointed by the prosecuting attorney . . . to perform the necessary duties . . . or if an assistant prosecuting attorney has been otherwise appointed by the prosecuting attorney pursuant to law and is not disqualified from acting in place of the prosecuting attorney."

Lansing Sch Ed Ass'n, 487 Mich at 372. Their complaint for superintending control, therefore, must also be dismissed for lack of standing.

Presiding Judge

A true copy entered and certified by Jerome W. Zimmer Jr., Chief Clerk, on

August 1, 2022
Date

Chief Clerk

STATE OF MICHIGAN
IN THE 6TH JUDICIAL CIRCUIT COURT FOR THE COUNTY OF OAKLAND

GRETCHEN WHITMER, on behalf of the State of Michigan,

Plaintiff,

v

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

Defendants.

Case No. 22-193498-CZ

Hon. Jacob Cunningham

AFFIDAVIT OF CHIEF MEDICAL EXECUTIVE NATASHA BAGDASARIAN

I, Natasha Bagdasarian, M.D., M.P.H., F.I.D.S.A, having been duly sworn, depose and say:

1. If sworn as a witness, I can testify competently to the facts contained within this affidavit.

2. I am the Chief Medical Executive ("CME") for the Michigan Department of Health and Human Services ("MDHHS"). In this role, I provide medical guidance for the State of Michigan as a cabinet member of the Governor.

3. In my role as CME, "responsible to the director for the medical content of [MDHHS] policies and programs" and must "assist in the development and implementation of the Department's public health mission and values to protect, promote, and preserve the health of Michigan residents." MCL 333.2202(2); MCL 333.26369(II)(I).

4. The facts I state here are based on my personal knowledge, information obtained through the course of my duties at DHHS, education, and training.

5. I understand that MCL 750.14 criminalizes abortion, even in cases of impacting the health of the mother. I understand that that if MCL 750.14 were enforced, Michigan doctors could be criminally prosecuted for providing an abortion at any point in pregnancy.

6. Enforcement or threatened enforcement of MCL 750.14 will immediately adversely affect those seeking abortions in Michigan as well as abortion providers and the public health.

7. As it relates to those individuals seeking abortions in Michigan, there are several circumstances in which time of the essence. For example, in the case of ectopic pregnancies timely intervention is crucial—e.g., before rupture versus after

rupture—and confusion regarding the legality of the intervention could negative impact the health of the women, and delayed intervention could increase the risk of death.

8. For nonviable pregnancies, delaying access to necessary emergency medical care could mean higher risk procedures, which could result in infection, sepsis, clotting, potential loss of future fertility, and/or death.

9. For those experiencing miscarriage, doctors may hesitate to perform dilation and curettage procedures for fear that it could be classified as pregnancy termination, which I understand would subject them to prosecution under MCL 750.14.

10. Further, the appropriate treatment for a pregnancy that present risks to the health of the mother can be abortion. Enforcement of MCL 750.14 is likely to result in health care providers hesitating to offer pregnancy termination, even in the cases that could jeopardize the life, health or future fertility of those pregnant.

11. As it relates to abortion providers, enforcement or threatened enforcement of MCL 750.14 will also have an immediate impact on the ability of abortion providers to provide appropriate and necessary medical care to patients.

12. As a medical doctor licensed in the State of Michigan and CME for MDHHS, I understand that medical providers have a duty to provide patients with treatment consistent with the medical standard of care.

13. I do not believe that MCL 750.14 permits medical professionals to provide the appropriate and necessary medical care to patients, which, as explained above,

could result in irreparable harm to vulnerable patients. Medical professionals will be forced to risk violating the medical standard of care, thereby incurring risk of civil and criminal liability on the one hand, and the risk of prosecution for providing care on the other.

14. Furthermore, medical professionals may be hesitant to provide care that they otherwise would provide due to a lack of clarity on the legality of services.

15. As it relates to the harm to the public health, MDHHS has a duty to "continually and diligently endeavor to prevent disease, prolong life, and promote the public health through organized programs, including . . . prevention and control of diseases; prevention and control of health problems of particularly vulnerable population groups; development of health care facilities and agencies and health services delivery systems; and regulation of health care facilities and agencies and health services delivery systems to the extent provided by law." MCL 333.2221(1).

16. MCL 750.14 is harmful to the public's health as it prevents healthcare providers from using their medical judgment to provide abortions consistent with the standard of care.

17. Additionally, the uncertainty surrounding when a physician's medical judgment may be criminalized by MCL 750.14 leaves me unable to fully discharge my duties as CME, as I cannot advise healthcare providers or the public as to the medical standard of care. I cannot assist MDHHS in issuing statewide guidance based on the medical standard of care relating to abortions within the confines of MCL 750.14.

18. Prior to August 1, 2022, MDHHS has provided information on a statewide basis regarding the then-current legal status of abortion throughout the entire state of Michigan.

19. As of August 1, 2022, MDHHS is no longer able to fulfil its duties under the Public Health Code to protect and promote public health for all Michigan residents and communities because the ability for patients to seek medical care now rests in the hands of county prosecutors, who are not medical or public health experts.

20. For these reasons, there is an imminent and real injury to those seeking abortions, abortion providers, and the public health. Absent an immediate injunction restraining the enforcement of MCL 750.14, this injury will not be abated.

AFFIANT SAYS NOTHING FURTHER.

Natasha Bagdasarian

Dr. Natasha Bagdasarian
Michigan Dep't of Health & Human Services

Subscribed and sworn to before me, a Notary Public,

on the 1st day of August, 2022

Candace Black

Notary Public Candace Black
Ingham County, Michigan

My Commission Expires: 12/16/2028

Notarized using electronic/remote technology

CANDACE BLACK
NOTARY PUBLIC, STATE OF MI
COUNTY OF INGHAM
MY COMMISSION EXPIRES Dec 16, 2028
ACTING IN COUNTY OF Ingham

Notary Certification under Public Act 336

I remotely notarized this document under Public Act 336, and certify:

1. The signatory signed this document while I was observing the signatory through a two-way real-time audiovisual technology that allowed direct, contemporaneous interaction by sight and sound between the signatory and me.

2. The two-way real-time audiovisual technology was capable of creating an audio and visual recording of the complete notarial act and such recording was made and retained as a notarial record in accordance with sections 26b(7) to 26b(9) of the Michigan Law on Notarial Acts, MCL 55.286b(7) to 55.286b(9).

3. The individual seeking my services and any required witnesses, if not personally known to me, presented satisfactory evidence of identity (e.g., a valid state-issued photo identification) to me during the video conference; they did not merely transmit that proof prior to or after the transaction, to satisfy the requirements of the Michigan Law on Notarial Acts, MCL 55.261 et seq., and any other applicable law.

4. The signatory affirmatively represented either that the signatory was physically situated in the State of Michigan, or that the signatory was physically located outside of Michigan's geographic boundaries and that either: (a) The document is intended for filing with or relates to a matter before a court, governmental entity, public official, or other entity subject to the jurisdiction of this state; or (b) The document involves property located in the territorial jurisdiction of this state or a transaction substantially connected to this state.

5. If the signatory was physically located outside of Michigan's geographic boundaries, I do not have actual knowledge that the signatory's act of making the statement or signing the document was prohibited by the laws of the jurisdiction in which she or he was physically located.

6. The signatory, any required witnesses, and I have affixed our signatures to the document in a manner that renders any subsequent change or modification of the remote online notarial act to be tamper-evident.

7. The signatory or the signatory's designee transmitted by fax, mail, or electronic means a legible copy of the entire signed document directly to me on the same date it was signed.

8. Upon receiving a legible copy of the document with all necessary signatures, I notarized the document and transmitted it back to the signatory.

9. I have certified the official date and time of the notarization as of the date and time when I witnessed the signatory's signature via two-way real-time audiovisual technology as required under the Public Act.

My full notarial certification is below; the foregoing representations are incorporated into that certification.

Candace Black

Candace Black

Dr. Natasha Bagdasarian, acknowledged this document before me on August 1, 2021. At the time of the acknowledgment, this person was located in Washtenaw County, Michigan, and I was located in Ingham County, Michigan. This document was notarized under Public Act 336; my representations regarding the circumstances of this notarial act are detailed in the preceding page of this document and are incorporated by reference into this certification.

Candace Black

Candace Black, Notary Public,
State of Michigan, County of Ingham
My commission expires 12/16/2028
Notary located in Ingham County, Michigan
Person making acknowledgment located in Ingham County, Michigan

CANDACE BLACK
NOTARY PUBLIC, STATE OF MI
COUNTY OF INGHAM
MY COMMISSION EXPIRES Dec 16, 2028
ACTING IN COUNTY OF Ingham

STATE OF MICHIGAN
IN THE COURT OF CLAIMS

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

Plaintiffs,

v

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

Defendant.

Case No.

Hon.

_____/

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

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

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

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

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

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

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

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

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

My Education and Professional Background

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

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

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

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

Planned Parenthood of Michigan

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

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

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

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

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

[1] See MCL 333.17015(3).

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

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

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

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

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

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

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

Pregnancy Has Significant Medical, Financial, and Personal Consequences

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

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

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

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

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

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

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

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[6] *Id.*

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

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

[9] *Id.* at 3–4.

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

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

[12] *Id.*

[13] *Id.* at 1676.

[14] *Id.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[31] *Id.*

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

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

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

[33] *Id.*

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

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

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

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

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

[39] See *id.*

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

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

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

[41] *Id.*

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

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

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

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

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

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

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

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

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

Background on Abortion

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

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

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

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

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

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

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

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

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

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

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

[55] *Id.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

My Medical Practice as an Abortion Provider

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Consequences of Banning Abortion in Michigan

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

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

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

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

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

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

[69] *Id.*

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

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

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

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

[71] See generally *id.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FURTHER AFFIANT SAYETH NAUGHT.

STATE OF MICHIGAN)
)ss
COUNTY OF WASHTENAW)

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

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

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

Signed:

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

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