No. 19A____

IN THE

Supreme Court of the United States

PLANNED PARENTHOOD CENTER FOR CHOICE, PLANNED PARENTHOOD OF GREATER TEXAS SURGICAL HEALTH SERVICES, PLANNED PARENTHOOD SOUTH TEXAS SURGICAL CENTER, WHOLE WOMAN'S HEALTH, WHOLE WOMAN'S HEALTH ALLIANCE, SOUTHWESTERN WOMEN'S SURGERY CENTER, BROOKSIDE WOMEN'S MEDICAL CENTER PA D/B/A BROOKSIDE WOMEN'S HEALTH CENTER AND AUSTIN WOMEN'S HEALTH CENTER, AND ROBIN WALLACE, M.D.,

Applicants,

v.

GREG ABBOTT, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF TEXAS; KEN PAXTON, IN HIS OFFICIAL CAPACITY AS ATTORNEY GENERAL OF TEXAS; PHIL WILSON, IN HIS OFFICIAL CAPACITY AS ACTING EXECUTIVE COMMISSIONER OF THE TEXAS HEALTH AND HUMAN SERVICES COMMISSION; STEPHEN BRINT CARLTON, IN HIS OFFICIAL CAPACITY AS EXECUTIVE DIRECTOR OF THE TEXAS MEDICAL BOARD; AND KATHERINE A. THOMAS, IN HER OFFICIAL CAPACITY AS EXECUTIVE DIRECTOR OF THE TEXAS BOARD OF NURSING,

Respondents.

EMERGENCY APPLICATION TO JUSTICE ALITO TO VACATE ADMINISTRATIVE STAY OF TEMPORARY RESTRAINING ORDER ENTERED BY THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

PATRICK J. O'CONNELL
Law Offices of Patrick J. O'Connell PLLC
5926 Balcones Dr., Ste. 220
Austin, Texas 78731
(512) 852-5918
pat@pjofca.com

JULIE A. MURRAY
Counsel of Record
HANNAH SWANSON
Planned Parenthood Federation of America
1110 Vermont Ave., NW, Ste. 300
Washington, DC 20005
(202) 973-4800
julie.murrary@ppfa.org
hannah.swanson@ppfa.org

ADDITIONAL COUNSEL AND REPRESENTATION INFORMATION ON NEXT PAGE

JENNIFER SANDMAN
Planned Parenthood Federation of America
123 William St., 9th Floor
New York, NY 10038
(212) 541-7800

STEPHANIE TOTI
RUPALI SHARMA
Lawyering Project
25 Broadway, 9th Floor
New York, NY 10004
(646) 490-1083

MOLLY DUANE
Center for Reproductive Rights
199 Water St., 22nd Floor
New York, NY 10038
(917) 637-3631

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TO THE HONORABLE SAMUEL A. ALITO, JR., ASSOCIATE JUSTICE OF THE SUPREME COURT AND CIRCUIT JUSTICE FOR THE FIFTH CIRCUIT:

On April 10, 2020, the U.S. Court of Appeals for the Fifth Circuit, for the second time in a matter of days, entered an administrative stay of temporary injunctive relief that would protect the constitutional right of pregnant Texans to obtain time-sensitive abortion care, and did so without any opportunity for Applicants to respond. As a consequence of the stay, virtually all Texas residents with unplanned pregnancies are unable to access early abortion care through medication abortion and must instead wait until they reach a more advanced stage of pregnancy. Delaying abortions by weeks does nothing to further the State's interest in combatting COVID-19, and indeed runs directly contrary to that interest: individuals will require more health care—even in the short-term—if they remain pregnant than if they have a desired abortion, and some will engage in risky, out-of-state travel in an attempt to access earlier abortion services, thus increasing contagion risks in the midst of a pandemic. This Court's intervention is urgently needed. Applicants respectfully request that the Fifth Circuit's administrative stay be vacated as to medication abortions provided up to 10 weeks of pregnancy.

The COVID-19 pandemic is a serious public health crisis. Every American, including each medical provider, has an obligation to make needed changes to combat it. To that end, virtually all health care providers—including Applicants—have changed their practices over the last two months to conserve personal protective equipment ("PPE") and to reduce the risk of COVID-19 transmission. Most governors have issued Executive Orders that recommend or require that physicians exercise their medical

judgment to determine which procedures should go forward and which can be postponed without risk to the patient.

On March 22, 2020, Texas Governor Greg Abbott issued the Executive Order that gave rise to this litigation. That order, which currently expires on April 21, 2020, but is expected to be extended, bars—under pain of criminal prosecution—the performance of all "surgeries and procedures" that are "not immediately medically necessary." App.81. The Executive Order specifically exempts surgeries and procedures that do not deplete the capacity of PPE or hospital beds necessary to confront the crisis. *Id.*

From there, certain Texas state officials—not least, the Attorney General of Texas—dramatically departed from the approach of their counterparts in other states by singling out abortion care as categorically prohibited by the order. They did so despite the fact that medication abortion is not a "procedure" at all, but instead involves taking oral medications. They ignored the conclusions of major medical authorities, including the American Medical Association ("AMA") and the American College of Obstetricians and Gynecologists ("ACOG"), which agree that abortion is time-sensitive health care that cannot be postponed without exposing patients to increased medical risks. And they failed to account for the fact that a person who cannot obtain an early abortion remains pregnant, and will ultimately require more PPE and hospital resources to have an abortion later on, to access pregnancy-related care, or ultimately to undergo labor and delivery.

The enforcement threat made by these State officials has had a profound chilling effect on the provision of abortion care in Texas, causing most doctors to cease providing abortions altogether. Hundreds of patients have already been turned away from

Applicants' facilities. To protect those patients' health and rights from the harms imposed by State officials' threat of enforcement, the district court entered a carefully tailored temporary restraining order ("TRO"), supported by extensive findings of fact, that permitted abortion in two specific categories—abortion induced by oral medications (commonly referred to as "medication abortion") and abortion for those who will be too late in pregnancy to obtain an abortion after the Executive Order's current expiration date. A divided panel of the Fifth Circuit, without waiting to hear from Applicants, granted an administrative stay of that TRO, except as applied to "'any patient who, based on the treating physician's medical judgment, would be past the legal limit for an abortion—22 weeks LMP [from the last menstrual period]—on April 22, 2020.'" App.4.

Thus, the Fifth Circuit's stay requires Applicants to cease providing early medication abortions or risk enforcement action by State officials.[1] No other court in the country has countenanced the type of categorical ban on medication abortion the State is attempting to enforce here as a response to the COVID-19 pandemic. Accordingly, Texas now has the most restrictive abortion policy in the nation.

Without this Court's urgent intervention, the Fifth Circuit's stay will continue to deny hundreds of Texas residents their constitutional right to obtain an abortion while exacerbating the current public health crisis, thereby inflicting irreparable harm. Patients who could otherwise obtain early medication abortions under the district court's

[1] The Fifth Circuit's stay also reinstates the threat of enforcement as to abortions provided to patients who would be past the legal limit for an abortion at a licensed clinic, as opposed to an ambulatory surgery center ("ASC"), on April 22, 2020, and would likely be unable to obtain care at an ASC. Applicants do not seek relief from that part of the Fifth Circuit's order at this time.

narrow TRO will be unable to obtain an abortion in Texas for at least several weeks. As a result, they will be forced either to remain pregnant and endure the physical, economic, and emotional consequences of pregnancy or to undertake risky and expensive travel to other states where abortion is still available. And if they do eventually obtain an abortion in Texas following expiration of the Executive Order, they will be forced to have an abortion later in pregnancy that carries a higher risk of complications and uses more PPE. These burdens are severe and ongoing.

By contrast, Respondents will suffer no harm from vacatur of the stay. Contrary to Respondents' claims, there is no evidence that prohibiting medication abortions will conserve hospital capacity or PPE to fight COVID-19. In fact, forcing Texans to travel out of state for abortion care or to remain pregnant for additional weeks (or months if the Executive Order is extended) harms public health by increasing the amount of PPE required to provide abortion or pregnancy-related care to patients, further straining hospital capacity, and increasing the risk of COVID-19 transmission as anxious patients fly or drive hundreds of miles across state lines to attempt to obtain abortion services.

The Fifth Circuit's extraordinary decision to impose an administrative stay of the TRO plainly departs from settled principles of law and has already resulted in serious and irreparable injury. As this Court is also likely to grant review of the Fifth Circuit's decision on Respondents' pending petition for a writ of mandamus or ultimate judgment in this case, vacatur of the stay is both warranted and urgently needed.

STATEMENT

A. The Governor's Executive Order

On March 13, 2020, Texas declared a state of disaster related to the COVID-19 pandemic. In anticipation of the impending strain on hospital capacity, Governor Greg Abbott issued an Executive Order on March 22, 2020, effective immediately, with two stated purposes: (1) conservation of hospital beds, and (2) conservation of the PPE necessary for medical providers to treat COVID-19 patients. App.80-81. Although the Executive Order does not define PPE, that term is generally understood to refer to N95 respirator masks, surgical masks, nonsterile and sterile gloves, and disposable protective eyewear, gowns, hair covers, and shoe covers. The Executive Order bars "all surgeries and procedures that are not immediately medically necessary," but exempts procedures that "would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster." App.81.

The Executive Order remains in effect through April 21, 2020, unless Governor Abbott rescinds or modifies it. App.81. Governor Abbott can extend the Order at any time, for any amount of time he deems necessary to respond to the pandemic. Federal officials and medical professionals expect the pandemic to last well past April 21. App.7-8, 255, 272. Experts further expect the COVID-related PPE shortage to last at least three to four months. App.7-8, 272.

The Executive Order has the "force and effect of law." App.80; Tex. Gov't Code Ann. § 418.012. Failure to comply with the Executive Order is a criminal offense punishable by a fine of up to $1,000, confinement in jail for up to 180 days, or both. Tex. Gov't Code Ann. § 418.173. Violation of the Executive Order may also trigger disciplinary

action against licensees by the Texas Health and Human Services Commission, the Texas Medical Board, or the Texas Board of Nursing. App.85.

On March 23, 2020, Texas Attorney General Ken Paxton issued a press release stating that provision of abortion care, other than for an immediate medical emergency, would violate the Executive Order. App.82. The Attorney General singled out abortion care, referring three separate times to the Executive Order's application to "abortion providers," and warned that "[t]hose who violate the governor's order will be met with the full force of the law." App.84. The Attorney General's statement does not distinguish between medication and procedural abortion.

The Attorney General's enforcement threat and the serious criminal and other penalties specified in the Executive Order have had a dramatic chilling effect on abortion in Texas. In light of the risk of enforcement, on March 23, 2020, Applicants, their physicians, and staff began cancelling hundreds of appointments.

On March 24, 2020, the Texas Medical Board ("Medical Board") adopted an emergency amendment to 22 Tex. Admin. Code § 187.57 ("Emergency Rule") incorporating the terms of the Executive Order. 22 Tex. Admin. Code § 187.57 (emergency regulation adopted Mar. 23, 2020).

Days later, the Medical Board published updated guidance regarding the scheduling of elective surgeries and procedures in light of Governor Abbott's COVID-19 disaster declaration. Tex. Med. Bd., *Updated Texas Medical Board (TMB) Frequently Asked Questions (FAQs) Regarding Non-Urgent Elective Surgeries and Procedures During Texas Disaster Declaration for COVID-19 Pandemic* (Mar. 29, 2020) ("TMB Guidance"), http://www.tmb.state.tx.us/idl/59C97062-84FA-BB86-91BF-F9221E4DEF17. The Medical

Board explained that postponing nonurgent, elective cases would preserve PPE, ventilator availability, and ICU beds. *Id.* It defined "urgent or elective urgent" procedures as those where "there is a risk of patient deterioration or disease progression that is likely to occur if the procedure or surgery is not undertaken immediately and/or … is significantly delayed." *Id.* It noted that the Executive Order's prohibition "does not apply to office-based visits without surgeries or procedures." *Id.* Further, it explained that "[a] 'procedure' does not include physical examinations, noninvasive diagnostic tests, the performing of lab tests, or obtaining specimens to perform laboratory tests." *Id.*

B. Abortion In Texas

Leading medical professional organizations, including the AMA and ACOG, have advised states not to categorize abortion as health care "that can be delayed during the COVID-19 pandemic" given its critical nature for patients, even if those states are requiring postponement of non-time-sensitive health care during the crisis.[2] That is so because "[t]here is a broad medical consensus that abortion is essential health care" that cannot be delayed. Br. of ACOG, et al. as Amici Curiae in Opp. to Pet. for Writ of Mandamus at 4, 10, *In re Greg Abbott*, No. 20-50264 (5th Cir. Apr. 2, 2020) ("ACOG Br."). Moreover, "[t]here is no evidence that prohibiting abortions during the pandemic will mitigate PPE shortages or promote public health and safety." *Id.* at 4.

Applicants are health care providers that offer, among other services, abortion care using two main methods: medication abortion and procedural abortion. App.10.

[2] ACOG et al., *Joint Statement on Abortion Access During the COVID-19 Outbreak* (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak.

Abortion is extremely safe, complications from abortion are rare, and those complications that do occur seldom result in hospital care. *See* ACOG Br. at 6-7; *see also Whole Woman's Health* v. *Hellerstedt*, 136 S. Ct. 2292, 2311-2312, 2315 (2016). These facts remain true for medication abortion: only 0.31 percent of medication abortions result in complications requiring hospitalization, surgery, or blood transfusion. App.245.

However, the health risks associated with abortion, as well as the health risks from pregnancy itself, increase with gestational age. App.15-16, 145-146, 161, 218, 229, 248. As ACOG and others have observed, "abortion is … a time-sensitive [service] for which a delay may increase the risks [to patients] or potentially make it completely inaccessible." ACOG Br. at 9. Delaying abortion "can compromise patients' health," as "[t]he chance of a major complication is higher in the second trimester than in the first trimester" of pregnancy. *Id.* at 10-11. Delays also result in increased health risks to a patient from a continuing pregnancy, as well as higher financial and emotional costs. App.16, 138-139, 145-146, 161, 228, 249, 303.

In Texas, except in narrow circumstances, abortion is illegal beyond 22 weeks of pregnancy, as dated from the first day of the patient's last menstrual period ("LMP"). Tex. Health & Safety Code §§ 171.044, 171.042. Abortion care is almost universally provided in an outpatient, nonhospital setting. App. 11, 185, 245. Applicants provide abortion exclusively at outpatient facilities that are not set up to provide inpatient care. App.89, 175, 251, 299.

Medication abortion is not a surgery or a "procedure"; the patient simply ingests two oral medications. App.10, 245-246. The patient takes the first medication at a health center and then generally takes the second medication 24 to 48 hours later at a location

of her choosing, often at home, after which she expels the pregnancy as in a miscarriage. *Id.* Medication abortion does not require the use of any PPE. App.11; *see also* App.88, 145, 156-157, 169, 175, 224, 250, 302.

While in other states medication abortion is commonly provided up to 11 weeks LMP, Texas law prohibits it after 10 weeks LMP. Tex. Health & Safety Code § 171.063(a)(2). If patients are prevented from obtaining an abortion past this early stage of pregnancy, they lose the option of medication abortion altogether; if they are able to obtain an abortion at all, they will be required to have a procedural abortion, which requires the use of more PPE. App.11-12. Moreover, depending on the duration of the delay, they may be forced to have a two-day procedure rather than a one-day procedure, which again requires the use of more PPE. App. 10-12.

The State has identified no other oral medication it considers prohibited by the Executive Order, which on its face applies only to "surgeries and procedures." As TMB's guidance on the Executive Order emphasizes, the order's "prohibition does not apply to office-based visits without surgeries or procedures." TMB Guidance at 3.

Applicants are committed to doing their part to protect patients and staff and to minimize use of PPE during the pandemic. Even before the Executive Order, Applicants had taken numerous steps to further those ends—by, for example, limiting the number of individuals present for any procedure that would require PPE and by curtailing nonabortion services that can safely be delayed, such as annual well-person visits and routine tests for sexually transmitted infections. App.88-90, 143-144, 160, 169-170, 175-176, 251-252, 302. Applicants have also taken extensive precautions to reduce the possibility of COVID-19 infection among patients and staff, by, for example, spreading

out patient appointments, conducting patient intake by phone, screening all patients before or upon entry for COVID-19 symptoms, and having patients wait in their cars instead of the waiting room until a clinician is ready to see them. App.88-90, 143-144, 157-158, 169-170, 175-176, 225, 251-252, 302. However, to meet the critical needs of their patients and where legally permitted, Applicants intend to continue providing abortion, including medication abortion, to patients during the pandemic.

C. The District Court's First TRO

Following the Attorney General's March 23, 2020, enforcement threat against abortion providers, Applicants sued in the U.S. District Court for the Western District of Texas to protect their patients' access to abortion. Applicants named as defendants Texas's Governor, Attorney General, Acting Executive Commissioner of the Texas Health and Human Service Commission, and the directors of the state medical and nursing boards, along with the local prosecutors in each Texas county where Applicants offer abortion care. They alleged violations of the Due Process and Equal Protection Clauses of the U.S. Constitution on behalf of themselves and their patients. Applicants sought a TRO and preliminary injunctive relief based on the due-process claim. In opposing Applicants' request for a TRO, State officials confirmed their categorical view that the Executive Order prohibits all abortions not involving a medical emergency, including medication abortions.

After permitting argument during a telephonic conference and reviewing Respondents' opposition to the TRO motion, the district court entered a TRO on March 30, 2020. The court found that Applicants had "established a substantial likelihood of success on the merits of their claim that the Executive Order, as interpreted by the

attorney general, violates Providers' patients' Fourteenth Amendment rights … by effectively banning abortions before viability." App.74. The court further observed that "[t]he Due Process Clause … protects a woman's right to choose abortion, and before fetal viability outside the womb, a state has *no interest* sufficient to justify an outright ban on abortions." *Id.* (citation omitted; alteration in original).

The district court likewise concluded that absent a TRO, Applicants' patients would "suffer serious and irreparable harm" from delayed access to abortion services and that some would be denied their constitutional right to abortion altogether if their pregnancies advanced to a stage at which abortion would no longer be available in Texas. App.76. The court further found that the Executive Order's significant harm to Applicants' patients outweighed any harm a TRO would cause to Respondents, particularly given that the ban would create only a "limited potential reduction," if any, of PPE. App.77. It also concluded that the preservation of Applicants' patients' constitutional rights served the public interest. *Id.* The court set a hearing for April 13, 2020, on Applicants' pending motion for a preliminary injunction.

That same day, Respondents filed a petition for writ of mandamus in the Fifth Circuit, and also moved for a stay of the TRO pending resolution of that petition, or in the alternative, an "administrative stay." Respondents reiterated their position that the Executive Order prohibits all abortions, absent a medical emergency. *See* Pet. for Writ of Mandamus at 17, *In re Greg Abbott*, No. 20-50264 (5th Cir. Mar. 30, 2020) ("the EO unambiguously prohibits … abortions").

The following morning, Applicants filed a letter with the Fifth Circuit indicating their intent to respond by 6 p.m. that day to the motion to stay the TRO pending

mandamus review and for an administrative stay. Without awaiting that filing, a divided panel of the Fifth Circuit administratively stayed the TRO without explanation. App.68-69. Judge Dennis dissented from that order. He would have denied the motion for an administrative stay and emphasized that the district court had already found that Texas residents seeking an abortion would suffer irreparable harm in the absence of a TRO. App.69. Applicants once again began cancelling appointments and sending home dozens of patients already waiting at their facilities for abortion care.

Though the stay motion was fully briefed on April 1, 2020, and the mandamus petition was fully briefed on April 3, 2020, the Fifth Circuit did not issue any further orders until late in the day on April 7, 2020, at which point the administrative stay of the TRO had been in place for a full week. On April 7, the same divided panel issued a writ of mandamus to the district court to vacate its TRO. The majority concluded that the district court had erred by not applying *Jacobson* v. *Commonwealth of Massachusetts*, 197 U.S. 11 (1905), which the panel described as setting forth "the framework [that] govern[s]" the constitutionality of "emergency public health measures like" the Executive Order. App.22. In addition, the majority rejected Applicants' argument that the Executive Order operates as an "outright ban" on abortion, instead viewing the Executive Order as a "temporary postponement" of access which operates only for abortions that are not necessary to "protect the health and life" of the patient. App.41.

Throughout its opinion, however, the majority acknowledged that the district court could still "make targeted findings, based on competent evidence, about the effects of [the Executive Order] on abortion access," and thus address the "validity of applying [the Executive Order] in specific circumstances." App.23. In this context, the Fifth

Circuit acknowledged that other federal courts had recently enjoined state orders similar to Texas's Executive Order, but distinguished those TROs on the grounds that they were "'narrowly tailored' and did not permit 'blanket' provision of abortions." App.30 n.18.[3] The majority also acknowledged that (1) the Executive Order contains an exception for procedures that would not deplete hospital capacity or PPE needed to cope with COVID-19, and that the district court had not made findings about the use of PPE in medication abortion, App.39, 42, and (2) relief may be appropriate for patients whose pregnancies will reach or exceed Texas's gestational age cut-off prior to the expiration date of the Executive Order, App.43. Judge Dennis again dissented.

D. The District Court's Second TRO

In line with the Fifth Circuit's suggestions, Plaintiffs filed a second motion for a TRO on April 8, 2020, seeking narrower relief. Specifically, Plaintiffs sought a TRO:

> enjoining enforcement of the Executive Order and Emergency Rule as to (1) medication abortion; and (2) procedural abortion where (a) based on the treating physician's medical judgment, the patients would be past the gestational age limit for an abortion in Texas (twenty-two weeks LMP) on April 22, 2020, and (b) based on the treating physician's medical judgment,

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[3] *See Preterm-Cleveland* v. *Att'y Gen. of Ohio*, 2020 WL 1673310, at *1-2 (6th Cir. Apr. 6, 2020) (concluding that TRO was "narrowly tailored" such that it would not "inflict irretrievable harms or consequences before it expires" where executive order did not prevent medication abortion and where TRO authorized provision of abortion "deemed legally essential to preserve a woman's right to constitutionally protected access to abortions" according to the health care provider's "determin[ation], on a case-by-case basis, that the surgical procedure is medically indicated and cannot be delayed"); *Robinson* v. *Marshall*, 2020 WL 1659700, at *3 (M.D. Ala. Apr. 3, 2020) (narrowing TRO in light of state defendants' representations that challenged executive order authorized provision of abortion where provider determined that, in her "reasonable medical judgment," the patient would otherwise "lose her right to lawfully seek an abortion in Alabama based on the [challenged] order's mandatory delays"); *South Wind Women's Ctr. LLC* v. *Stitt*, 2020 WL 1677094, at *2, *5-6 (W.D. Okla. Apr. 6, 2020) (entering TRO as to medication abortion and "requirements that effectively deny a right of access to abortion"), *appeal filed*, No. 20-6045 (10th Cir. Apr. 7, 2020).

> the patient would be more than eighteen weeks LMP and therefore no longer be eligible to have an abortion in a licensed abortion facility in Texas on April 22, 2020, and the patient would [] likely be unable to obtain care at an ASC at or after that time.

Pls.' Second Mot. for a TRO & Mem. in Support at 16, No. 1:20-cv-00323 (W.D. Tex. Apr. 8, 2020), ECF No. 56.

The district court granted that second TRO, finding that the Attorney General's interpretation of the Executive Order "creates a credible threat of enforcement against Plaintiffs and their agents for the provision of *any* abortion." App.9 (emphasis added). The district court further found that Applicants "have ceased providing nearly all abortion care" and have already "turned away hundreds of patients seeking abortion care" while the Executive Order has been in place. App.10, 14. As a result, the court found, "some patients have *already* exceeded the gestational age limit to obtain an abortion in Texas while the Executive Order has been in place." App.15. Some patients have also traveled "by both car and airplane to places as far away as Colorado and Georgia," which "increases an individual's risk of contracting COVID-19." App.14.

Moreover, the district court found that because "[t]he health risks associated with both pregnancy and abortion increase with gestational age," App.15, "delaying access to abortion will not conserve hospital resources," App.14. It also concluded that "individuals with ongoing pregnancies require more in-person healthcare, including lab tests and ultrasounds, at each stage of pregnancy than individuals who have previability abortions." App.13. As a result, "delaying access to abortion will not conserve PPE." *Id.* Additionally, the district court found that "[p]roviding medication abortion does not

require the use of any PPE," App.11; that procedural abortions use minimal PPE, App.12; and that "[a]bortion providers generally do not use N95 masks," App.13.

Based on these factual findings, the district court concluded that the Executive Order, as interpreted by Respondents, "is an undue burden on a woman's right to a previability abortion." App.17. It likewise held that application of the Executive Order to medication abortion, as well as the other circumstances described in the TRO, "violates the standards set forth in both *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833 (1992), and *Jacobson* v. *Commonwealth of Massachusetts*, 197 U.S. 11 (1905)." *Id.* The court concluded that Applicants and their patients "will suffer irreparable harm in the absence of a [TRO]." App.18.

As with the first TRO, the following morning, Respondents filed a motion to stay and a mandamus petition with the Fifth Circuit. Applicants informed the Fifth Circuit Clerk's office that they would file a brief in opposition to the stay by 5 p.m. CST that same day. However, just after 3 p.m. CST, the same Fifth Circuit panel, again divided, granted another administrative stay of the district court's TRO, except as to those patients whose pregnancies would exceed 22 weeks or more on April 22. App.1-4.[4]

Accordingly, with the exception of approximately 24 hours when the first TRO was in effect and approximately 24 hours when the second TRO was in effect, Applicants

[4] Briefing on Respondents' pending motion for stay and petition for writ of mandamus will not be complete in the Fifth Circuit until April 13 and April 15, respectively. Meanwhile, preparation for an evidentiary hearing on the preliminary injunction motion in the district court is underway; the parties have until April 15 to propose a new date for that hearing.

have now been forced to turn away patients for abortion care in Texas for almost three weeks, resulting in a denial of care to hundreds of patients.

Upon entry of the Fifth Circuit's administrative stay of the second TRO on April 10, 2020, Applicants filed an emergency motion with the Fifth Circuit asking that the administrative stay be lifted before day's end. App.314. The Fifth Circuit effectively denied this motion by ordering the State officials to file a response by Saturday, April 11, at 5 p.m. CST. App.333.

STANDARD OF REVIEW

The full Court or Circuit Justice has jurisdiction to vacate a stay by a court of appeals, including one characterized as an "administrative stay," *see Office of Pers. Mgmt.* v. *American Fed'n of Gov't Emps.*, 473 U.S. 1301, 1306 (1985) (Burger, C.J., in chambers), "regardless of the finality of the judgment below," *Western Airlines, Inc.* v. *International Bhd. of Teamsters*, 480 U.S. 1301, 1305 (1987) (O'Connor, J., in chambers).

The Court, or a Circuit Justice, may vacate a stay entered by a court of appeals if the applicant shows (1) "a reasonable probability that four Justices will consider the issue sufficiently meritorious to grant certiorari"; (2) "a fair prospect that a majority of the Court will vote to reverse the judgment below"; and (3) "a likelihood that irreparable harm will result" from the denial of the relief sought. *Hollingsworth* v. *Perry*, 558 U.S. 183, 190 (2010) (per curiam); *see also, e.g.*, *Reynolds* v. *International Amateur Athletic Fed'n*, 505 U.S. 1301 (1992) (Stevens, J., in chambers) (in determining whether to vacate stay of preliminary injunction, "[t]he dispositive questions … are, first, whether the applicant has established a probability of success on the merits, and second, … irreparable harm.").

ARGUMENT

Vacatur of the Fifth Circuit's stay is clearly warranted.

First, the Fifth Circuit's stays have already seriously and irreparably injured Applicants' patients and leaving the current stay in place will compound this harm. In denying patients access to medication abortion, the stay singles out medication abortion as the only oral medication that cannot be provided under the Executive Order—even though its provision requires no PPE and delaying it forces patients to undergo more invasive abortion procedures later in their pregnancies or to attempt to travel out of state to access early abortion. On the other hand, Respondents will suffer little harm if the TRO remains in place until the preliminary injunction hearing because the Executive Order, as applied to medication abortions, will exacerbate rather than alleviate shortages of PPE and hospital capacity necessary to combat the COVID-19 pandemic.

Second, the Fifth Circuit plainly erred in imposing an administrative stay of the TRO. In doing so, the court failed to give due consideration of the irreparable harm that would result from the stay. Further, the court of appeals effectively gave Respondents the relief they are seeking in their petition for a writ of mandamus, and that writ plainly should not issue. In temporarily enjoining the Executive Order's enforcement to permit a narrow category of abortions during the pandemic, the district court faithfully adhered to the Fifth Circuit's earlier mandamus opinion, which in turn purported to apply this Court's longstanding precedent on both the fundamental right to terminate a pregnancy and a state's ability to take appropriate measures during a public health crisis. While Applicants disagree with the Fifth Circuit's articulation of the applicable analysis, under any interpretation this precedent makes clear that a state may not suspend, or

substantially restrict, the constitutional right to abortion during a public health crisis when doing so does not actually advance public health in a material way.

Finally, this Court is likely to grant review of this case upon the Fifth Circuit's resolution of the pending petition for a writ of mandamus or after a direct appeal of the district court's decision on the pending preliminary injunction motion. Numerous other cases involving similar state restrictions on abortion during the COVID-19 pandemic are currently in the federal courts and, notably, none has permitted a prohibition as extreme as the one Texas seeks to impose here, with the Fifth Circuit's approval. *See South Wind Women's Ctr. LLC* v. *Stitt*, 2020 WL 1677094 (W.D. Okla. Apr. 6, 2020), *appeal filed*, No. 20-6045 (10th Cir. April 7, 2020); *Robinson* v. *Marshall*, 2020 WL 1520243 (M.D. Ala. Mar. 30, 2020), *appeal voluntarily dismissed*, No. 20-11270 (11th Cir. Apr. 4, 2020); *Preterm-Cleveland* v. *Yost*, No. 19-cv-00360 (S.D. Ohio Mar. 30, 2020), ECF No. 43 ("Ohio Order"), *appeal dismissed*, No. 20-3365 (6th Cir. Apr. 6, 2020). Indeed, absent intervention by this Court, this stay makes Texas the only state in the country permitted to enforce an interpretation of a COVID-19 executive order that categorically bars medication abortion. The issues presented by this case are ones of national importance whose urgency merits this Court's review at the earliest possible time.

I. THE STAY IMPOSES SERIOUS AND IRREPARABLE INJURY ON APPLICANTS' PATIENTS AND THE PUBLIC

The Fifth Circuit's stay is severely and irreparably injuring Applicants' patients—particularly those seeking early abortions—and it will continue to do so absent this Court's intervention. Applicants have already had to turn away hundreds of patients seeking abortion care and will have to turn away hundreds more absent reinstatement of

a TRO. App.14, 88, 90, 143, 159-160, 163, 170, 177-178, 227, 231, 252-253, 301; *see also*, *e.g.*, App. 168 (in 2019 half of the abortions they provided were medication); App.223 (in a "typical" week the Austin clinic provides medication abortions to approximately 30 patients). These cancellations have left patients "devastated," "scared," "stunned," and "anguish[ed]." App.163, 151, 139-140, 232. Even if this Court promptly intervenes to lift the stay, some patients' pregnancies will have advanced beyond the legal limit for medication abortion in Texas and—because procedural abortion is currently unavailable because of the Executive Order as well—they will have no access to abortion in the State. App.146, 161, 231, 253, 271, 303.

Moreover, it is undisputed that the risk of a serious complication from abortion increases with weeks' gestation. App. 15-16, 161, 170, 228-229, 254-255. The same is true of the ongoing health risks to individuals of remaining pregnant, which increase over the course of a pregnancy. App.161, 229. Delays in the availability of abortion care necessarily lead patients to require more invasive, time-consuming, and expensive abortion procedures. App.161, 170, 229, 254-255. And some individuals anxious to end their pregnancies may resort to unsafe methods to induce abortion. *See* ACOG Br. at 12-14.

In addition to increasing health risks, delayed access to abortion imposes financial and emotional costs on people with unwanted pregnancies. For example, people with ongoing pregnancies must struggle to conceal their pregnancies from abusive partners or family members, and must deal with the stress and anxiety of not knowing when—or if—they will be able to obtain an abortion. App.16; *see also* App.139-140, 161, 228, 232, 240-241, 308-309. Individuals also bear emotional costs of being forced to carry a pregnancy

for weeks, despite desiring an abortion far earlier. App.15; *see also* App.164, 227, 231-232, 307-309.

Second, continued imposition of the stay will do irreparable injury to public health by increasing, not decreasing, demands for PPE and hospital resources. It will drive up the use of needed PPE because a pregnant patient denied an abortion remains pregnant and will require medical care related to pregnancy. At every stage of pregnancy, a pregnant person will need services—including ultrasound imaging, lab tests, and other diagnostic tests—that require the use of more PPE than abortion. App.130-132, 184-188, 220. These ultrasounds and other diagnostic tests are not covered by the Executive Order and are thus not banned during the pandemic. *See* TMB Guidance; App.9, 11-12. Further, people with ongoing pregnancies are more likely to require treatment in a hospital for a wide range of conditions than people who have abortions. App.184-185, 220, 251; *see also* *Whole Woman's Health* v. *Hellerstedt*, 136 S. Ct. 2292, 2311 (2016).

In addition, the longer an abortion is delayed, the more PPE the abortion procedure itself will require. Medication abortion available in the first 10 weeks of pregnancy, as explained above, requires no PPE. After 10 weeks, a patient's only option in Texas is procedural abortion. Patients delayed past 14 to 16 weeks LMP are no longer eligible for an aspiration abortion, and must instead have a dilation and evacuation ("D&E") abortion, which later in the second trimester becomes a two-day procedure requiring two consecutive trips to a health center, twice as much contact with health care providers, and at least twice the amount of PPE. App.10-11; *see also, e.g.*, App.161, 177, 228-229, 246-247, 254-255. The Fifth Circuit's stay means more patients will require more PPE-intensive abortions, and some patients will be entirely deprived of their

constitutional right to an abortion given Texas's regulations and the cost of later abortion care.

Moreover, in response to the stay, some patients will attempt to leave Texas—as some are already doing—to obtain abortion care in other states, driving or flying as far away as Colorado and Georgia, which exposes patients and third parties to greater risk of COVID-19 infection than seeking care locally. App.14; *see also* App.151-152 (describing patient's three-day trip to Colorado for abortion care shortly after the Attorney General's statement); App.233 (one out-of-state provider treated 30 abortion patients from Texas in the week after the Attorney General's statement); App.163 (at least four patients denied care at one Texas health center flew to Colorado for care, and another three drove roughly 11 hours to New Mexico); App.307-308 (average distance traveled by clients for abortion care has increased from 158 miles in 2019 to 734 miles after the Executive Order). The record shows that patients traveling to other States for abortion care include patients seeking medication abortion. App.150, 152.

In sum, as the record demonstrates, vacatur of the stay of the TRO with respect to medication abortion is necessary to restore some abortion access in Texas and prevent ongoing irreparable harm to patients and the public health. Respondents will suffer no harm if the stay is vacated because, for the reasons discussed above, their threatened enforcement of the Executive Order undermines rather than advances their stated public health goals.

II. THE FIFTH CIRCUIT WAS DEMONSTRABLY WRONG IN ITS APPLICATION OF ACCEPTED STANDARDS TO ISSUE THE STAY

The court of appeals' decision to enter an administrative stay of the TRO pending resolution of the mandamus petition plainly departs from this Court's precedent. To warrant a stay, Respondents had the burden to demonstrate: (1) "a strong showing" that they are likely to succeed on their petition for writ of mandamus; (2) that they are likely to suffer irreparable injury absent a stay; (3) that Providers and their patients will not be substantially harmed by a stay; and (4) that granting the stay will serve the public interest. *Nken* v. *Holder*, 556 U.S. 418, 425-426, 434 (2009) (citations omitted).

Respondents cannot possibly demonstrate that they are likely to prevail on their pending mandamus petition. Mandamus is a "drastic and extraordinary" remedy "reserved for really extraordinary causes." *Cheney* v. *U.S. Dist. Ct. for D.C.*, 542 U.S. 367, 380 (2004). To obtain the writ before the Fifth Circuit, Respondents must show that they have (1) a "clear and indisputable" right to the writ, (2) "no other adequate means to attain … relief," and (3) the writ is otherwise warranted. *Id.* at 380-381. They cannot do so here. Moreover, the remaining equitable factors relevant to a stay favor Applicants and restoration of the district court's TRO.

A. Respondents Are Not Likely To Succeed On Their Mandamus Petition

Even during a crisis, fundamental rights secured by the U.S. Constitution remain steadfast, *see Ex parte Milligan*, 71 U.S. (4 Wall.) 2, 120-121 (1866), and this Court's precedents, from *Jacobson* to *Casey*, all establish that the State cannot ban early abortion

during a pandemic.[5] While the government has authority to "safeguard the public health and the public safety" in an emergency, the State may not—even while exercising that power—impose a restriction that is "a plain, palpable invasion of rights secured by the fundamental law." *Jacobson* v. *Commonwealth of Massachusetts*, 197 U.S. 11, 25, 31 (1905). Regardless of whether the Executive Order's prohibition of medication abortion operates as an outright ban on previability abortion at early gestational ages, or—as the Fifth Circuit characterized it—a temporary restriction, it is "beyond question that the Executive Order's burdens outweigh the order's benefits as applied to" patients seeking medication abortion. App.17.

First, as applied to medication abortion, the Executive Order does not serve the State's asserted interests in reducing PPE use, conserving hospital capacity, or preventing COVID-19 exposure. Specifically, based on evidence provided in 20 declarations submitted by Applicants, the district court found that "[p]roviding medication abortion does not require the use of any PPE," while the alternative—continuing the pregnancy—"will not conserve PPE." App.11, 13. The court also concluded that complications associated with medication abortion, including those requiring

[5] In the years since *Casey*, federal courts of appeals have uniformly struck down previability bans on abortion as incompatible with *Roe* v. *Wade*, 410 U.S. 113 (1973), and this Court has consistently declined to grant certiorari to reconsider the issue. *See, e.g.*, *MKB Mgmt. Corp.* v. *Stenehjem*, 795 F.3d 768, 772-773 (8th Cir. 2015) (six-week ban), *cert. denied*, 136 S. Ct. 981 (2016); *Edwards* v. *Beck*, 786 F.3d 1113, 1117-1119 (8th Cir. 2015) (per curiam) (twelve-week ban), *cert. denied*, 136 S. Ct. 895 (2016); *Isaacson* v. *Horne*, 716 F.3d 1213, 1217, 1231 (9th Cir. 2013) (20-week ban), *cert. denied*, 571 U.S. 1127 (2014); *Jane L.* v. *Bangerter*, 102 F.3d 1112, 1117-1118 (10th Cir. 1996) (22-week ban), *cert. denied*, 520 U.S. 1274 (1997); *Sojourner T.* v. *Edwards*, 974 F.2d 27, 29, 31 (5th Cir. 1992) (ban on all abortions), *cert. denied*, 507 U.S. 972 (1993); *Guam Soc'y of Obstetricians & Gynecologists* v. *Ada*, 962 F.2d 1366, 1368-1369, 1371-1372 (9th Cir. 1992) (ban on all abortions), *cert. denied*, 506 U.S. 1011 (1992).

hospital care, are exceedingly rare, App.11; *see also Whole Woman's Health*, 136 S. Ct. at 2311-2312, 2315, and that (as is true with abortion generally) nearly all medication abortions are provided in outpatient facilities, not hospitals, App.11.[6] In contrast, the district court concluded that individuals who remain pregnant "are more likely to seek treatment in a hospital" than individuals who have previability abortions. App.14. Moreover, the district court found that some patients are already traveling across state lines to obtain abortion care elsewhere, *id.*, including medication abortion, *id.*, therefore increasing the risk of exposure to COVID-19 relative to obtaining care closer to home. In light of this evidence, the Executive Order's prohibition on medication abortion lacks any "real or substantial relation" to the public health goals on which the State relies. *Jacobson*, 197 U.S. at 31.

While State officials assert that medication abortion results in complications necessitating "surgical intervention" 8 to 15 percent of the time, State Defs.' Resp. to Pls.' Mot. for TRO at 17-18, *Planned Parenthood Ctr. for Choice* v. *Abbott*, No. 1:20-cv-00323 (W.D. Tex. Mar. 30, 2020) ("Defs.' TRO Resp."), ECF No. 30, the rates they cite are not for complications requiring hospitalization,[7] but rather are outdated figures referring to the incidence of medication abortions that are completed using aspiration. More current data show that the regimen on the label for one of the medications involved in medication

[6] Tex. Health & Human Servs., *Induced Terminations of Pregnancy, 2017 Selected Characteristics of Induced Terminations of Pregnancy (2018)*, https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/itop-statistics (in 2017, 99.8 percent of abortions among Texas residents in Texas were provided in abortion facilities or ASCs).

[7] In fact, only 0.31 percent of medication abortions result in complications requiring hospitalization, surgery, or blood transfusion. App.245; *see also* App.11.

abortion, which has been approved by the U.S. Food and Drug Administration and is used by Applicants, has an aspiration follow-up rate of 2.6 percent.[8] And for those patients, aspiration involves the same incision-free suction procedure used for early procedural abortions; it takes approximately five to 10 minutes in an outpatient setting. App.11; *see also* App.185, 246. Hospital treatment related to an ongoing pregnancy is far more common. App.13; *see also* App. 185 ("[A]t least twenty percent of pregnant patients will visit a hospital at some point prior to delivery, and some patients will visit the hospital for evaluation or treatment on multiple occasions.").

State officials also assert that prohibiting medication abortion saves PPE because, under Texas law, a medication abortion must be preceded by an ultrasound and offered in conjunction with a follow-up visit. Tex. Health & Safety Code §§ 171.012, 171.063(e); Tex. Admin. Code § 139.53(b)(4); *see also* App.88-89, 156, 175, 223, 246, 249. However, the record establishes that medication abortion, including any incidental lab work and diagnostic testing, requires the use of less PPE than the monthly diagnostic tests and ultrasounds that are required for a patient with an ongoing pregnancy. App.13; *see also* App.185-186, 220, 251.[9] In any event, as the district court found, the Texas Medical Board's own guidance makes clear that "physical examinations, non-invasive diagnostic

[8] Defs.' TRO Resp. at 16 n.33 (citing U.S. Food & Drug Admin., Mifeprex 13 tbl.3 (rev. Mar. 2016), https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf (listing rate of 2.6 percent for "surgical intervention" due to ongoing pregnancy, medical necessity, persistent or heavy bleeding after treatment, patient request, or incomplete expulsion)).

[9] Transabdominal ultrasounds do not require the use of any PPE. App.11-12, 157, 219, 224. Transvaginal ultrasounds, if necessary, require the use of one pair of nonsterile gloves, at most. App.12, 157, 219, 224.

tests, the performing of lab tests, or obtaining specimens to perform laboratory tests" are not "procedures" and are therefore not covered by the Executive Order. App.9.

Against the Executive Order's nonexistent benefits, the burden of the order as applied to medication abortion patients is severe and ongoing. Even assuming the Executive Order is not extended beyond April 21, it subjects all patients to at least a month-long delay—a delay many orders of magnitude larger than the 24-hour delay permitted by this Court in *Planned Parenthood of Se. Pa.* v. *Casey*, 505 U.S. 833 (1992). App.81. Moreover, record evidence demonstrates that the Executive Order will, in fact, cause an even longer delay for these patients because abortion providers in Texas will not be capable of absorbing the full backlog of patients in need of abortion care after the Executive Order expires. App.15; *see also* App.164, 234-235. As noted, these delays will lead to greater health risks for pregnant individuals, force patients to travel to other states during a pandemic to obtain abortion care, and impose numerous other financial and emotional costs. Balanced against the Executive Order's illusory benefits as applied to medication abortion, these burdens are unquestionably "undue." *Casey*, 505 U.S. at 857.

In addition, the Executive Order, as interpreted by State officials, singles out medication abortion for differential treatment. *See Jacobson*, 197 U.S. at 26 (law justified on public safety grounds may not be "unreasonable, arbitrary, [or] oppressive"). State officials have identified no other oral medication they consider prohibited by the Executive Order, which on its face applies only to "surgeries and procedures." App.81. Moreover, the record shows that treatments comparable to medication abortion, and those other aspects of medical care that accompany it, are exempt from the Executive

Order's requirements. *See* App.7, 14; *see also* App.187 (obstetric care like blood draws, ultrasounds, and other in-person diagnostics still performed during prenatal visits); App.311-313 (ultrasound examinations still being performed for obstetrical patients). Meanwhile, Texas would deny medication abortion patients access to care altogether. Under these circumstances, the record demonstrates that Texas has exploited the COVID-19 crisis as a pretext to target abortion, thus justifying judicial intervention.

B. Respondents Have An Effective Remedy

Respondents cannot prevail on their petition for a writ of mandamus for the additional reason that they have an effective remedy through the normal litigation and appeal process. *See Kerr* v. *U.S. Dist. Ct. for N. Dist. of Cal.*, 426 U.S. 394, 403 (1976). The TRO is in effect until April 19, and if a preliminary injunction is granted, Respondents will have an immediate right to appeal. 28 U.S.C. § 1292(a). Accordingly, Respondents would have an adequate remedy later in litigation. *See Allied Chem. Corp.* v. *Daiflon, Inc.*, 449 U.S. 33, 36 (1980) ("[M]andamus indisputably undermines the policy against piecemeal appellate review[.]"); *see also*, *e.g.*, *Wilson* v. *U.S. Dist. Ct. for N. Dist. of Cal.*, 161 F.3d 1185, 1187 (9th Cir. 1998) (denying mandamus review of TRO staying prisoner's execution where "[t]he district court ha[d] scheduled a full show cause hearing on issuance of a preliminary injunction for December 3, 1998, which [was] less than three weeks hence," and "[t]hat order [would] be fully reviewable on appeal and expedited proceedings [could] be requested").

III. THIS COURT WOULD LIKELY GRANT REVIEW OF A WRIT OF MANDAMUS ENTERED BY THE FIFTH CIRCUIT

Vacatur of the Fifth Circuit's administrative stay is appropriate for the final reason that this Court "could and very likely would" review a decision from the mandamus petition currently pending in the Fifth Circuit or from a direct appeal of the district court's grant or denial of the preliminary injunction. *Western Airlines*, 480 U.S. at 1305.

This case will present the question whether a district court may partially enjoin a previability abortion ban during the COVID-19 pandemic when the court determines that the ban is not reasonably designed to protect public health. That question is currently at issue in other cases pending in the federal courts. Specifically, district courts in Ohio, Alabama, and Oklahoma have issued TROs enjoining the enforcement of respective state orders purporting to ban abortions during the pandemic in order to preserve PPE and hospital capacity. Those courts held that plaintiffs were likely to succeed in their challenges to a ban on abortion based on the COVID-19 pandemic where continued access to abortion care would not impede necessary conservation of PPE and hospital capacity. *See South Wind Women's Ctr.*, 2020 WL 1677094, at *4-5; *Robinson*, 2020 WL 1520243, at *2; Ohio Order 5-6.[10]

In circumstances as time-sensitive and pressing as these, any conflict on this question among lower courts would warrant granting certiorari, despite the absence of

[10] The TRO in the Alabama case was later partially stayed, following clarification by defendants that the executive order would not prohibit all abortions, and would instead permit "providers, exercising their reasonable medical judgment, to protect their patients' right to terminate a pregnancy." *Robinson*, 2020 WL 1659700, at *3.

conflicting decisions from courts of appeals to date. *Cf. Mistretta* v. *United States*, 488 U.S. 361, 371 (1989) (granting certiorari before judgment in part "because of the disarray among the Federal District Courts"); *see also* Pet. for Writ of Cert. at 16, *United States Dep't of Homeland Security* v. *Regents of the Univ. of Cal.*, No. 18-587 (U.S. Nov. 5, 2018) (observing, amidst division among courts of appeals and district courts, that "[o]nly this Court can resolve the conflict in the lower courts and provide much-needed clarity"). Given that other States' officials have also suggested an interest in using the pandemic as a justification for banning abortion, more challenges like this are bound to follow. Guidance from this Court is urgently needed.

In addition, this Court is likely to grant certiorari review of the Fifth Circuit's mandamus decision or a decision on appeal from a preliminary injunction order because such decisions will present questions of national importance. *See* Sup. Ct. R. 10(c). Where, as here, important constitutional issues are at stake, this Court will grant certiorari even absent a conflict among the lower courts. *See, e.g.*, *June Medical Servs. L.L.C.* v. *Gee*, Nos. 18-1323, 18-1460 (U.S.); *New York State Rifle & Pistol Ass'n* v. *City of N.Y.*, No. 18-280 (U.S.). Moreover, application of the Executive Order to abortion providers in Texas, and similar measures in other States, is already having severe negative public health effects, not only in the States using this national emergency to further their own anti-abortion agendas, but also in neighboring States where patients are traveling for abortion care. The drastic consequences of the Executive Order for public health, women's health, and the constitutional right to a previability abortion plainly present issues of national importance warranting this Court's review.

CONCLUSION

This Court has continually recognized the importance of maintaining injunctions against enforcement of drastic state restrictions on access to previability abortion, pending later review. *See Whole Woman's Health* v. *Hellerstedt*, 136 S. Ct. 2292, 2303 (2016); *June Medical Servs. L.L.C.* v. *Gee*, 139 S. Ct. 663, 663 (2019). For the foregoing reasons, the Court should do the same here and vacate the stay entered by the United States Court of Appeals for the Fifth Circuit.

Respectfully submitted.

/s/ Julie A. Murray

JULIE A. MURRAY
Counsel of Record
HANNAH SWANSON
Planned Parenthood Federation of America
1110 Vermont Ave., NW, Ste. 300
Washington, DC 20005
(202) 973-4800
julie.murrary@ppfa.org
hannah.swanson@ppfa.org

PATRICK J. O'CONNELL
Law Offices of Patrick J. O'Connell PLLC
5926 Balcones Dr., Ste. 220
Austin, Texas 78731
(512) 852-5918
pat@pjofca.com

JENNIFER SANDMAN
Planned Parenthood Federation of America
123 William St., 9th Floor
New York, NY 10038
(212) 541-7800

STEPHANIE TOTI
RUPALI SHARMA
Lawyering Project
25 Broadway, 9th Floor
New York, NY 10004
(646) 490-1083

MOLLY DUANE
Center for Reproductive Rights
199 Water St., 22nd Floor
New York, NY 10038
(917) 637-3631

April 11, 2020

CORPORATE DISCLOSURE STATEMENT

Plaintiff Planned Parenthood Center for Choice has no parent corporation, and no publicly held corporation holds 10% or more of its shares.

Plaintiff Planned Parenthood of Greater Texas Surgical Health Services has no parent corporation, and no publicly held corporation holds 10% or more of its shares.

Plaintiff Planned Parenthood South Texas Surgical Center is a subsidiary of Planned Parenthood South Texas. No publicly held corporation holds 10% or more of shares in either organization.

Plaintiff Whole Woman's Health is the doing business name of a consortium of limited liability companies held by a holding company, the Booyah Group, which includes Whole Woman's Health of McAllen, LLC, and Whole Woman's Health of Fort Worth, LLC. Whole Woman's Health has no parent corporation, and no publicly held corporation holds 10% or more of its shares.

Plaintiff Whole Woman's Health Alliance is a Texas non-profit corporation. It has no parent corporation, and no publicly held corporation holds 10% or more of its shares.

Plaintiff Southwestern Women's Surgery Center has no parent corporation, and no publicly held corporation holds 10% or more of its shares.

Plaintiff Brookside Women's Medical Services PA d/b/a Brookside Women's Health Center and Austin Women's Health Center has no parent corporation, and no publicly held corporation holds 10% or more of its shares.

s/ Julie A. Murray
JULIE A. MURRAY
Counsel of Record

APPENDIX
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IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 20-50296

In re: GREG ABBOTT, in his official capacity as Governor of Texas; KEN PAXTON, in his official capacity as Attorney General of Texas; PHIL WILSON, in his official capacity as Acting Executive Commissioner of the Texas Health and Human Services Commission; STEPHEN BRINT CARLTON, in his official capacity as Executive Director of the Texas Medical Board; KATHERINE A. THOMAS, in her official capacity as the Executive Director of the Texas Board of Nursing,

Petitioners

Petition for Writ of Mandamus
to the United States District Court
for the Western District of Texas

Before DENNIS, ELROD, and DUNCAN, Circuit Judges.

PER CURIAM:

On April 7, 2020, we issued a writ of mandamus directing the district court to vacate its temporary restraining order ("TRO") that exempted abortion procedures from GA-09, an emergency executive order issued on March 22 by the Governor of Texas postponing certain non-essential medical procedures for three weeks during the escalating COVID-19 pandemic. *See In re Abbott*, --- F.3d ---, 2020 WL 1685929 (5th Cir. April 7, 2020). As we explained, GA-09 sought to preserve critical medical resources and slow the spread of a pandemic during what the district court itself recognized was Texas's "worst public health emergency in over a century." *Id.* at *1, 4, 9. We further explained that GA-09 "is a concededly valid public health measure that applies to all

'surgeries and procedures,' does not single out abortion, and . . . has an exemption for serious medical conditions." *Id.* at *10.

In our opinion, we emphasized that the district court had "scheduled a telephonic preliminary injunction hearing for April 13, 2020, when all parties will presumably have the chance to present evidence on the validity of applying GA-09 in specific circumstances." *Id.* at *2. The evidence presented at this hearing, we said, would allow the district court to make "targeted findings, based on competent evidence, about the effects of GA-09 on abortion access." *Id.* We emphasized that "those proceedings" must "adhere to the controlling standards, established by the Supreme Court over a century ago, for adjudging the validity of emergency measures like [GA-09]." *Id.* As we stated in our opinion, those "controlling" standards come from the Supreme Court's decision in *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11 (1905). *In re Abbott,* 2020 WL 1685929, at *1, 6–7. Having already painstakingly explained those standards in our opinion, we reiterate our holding:

> [W]hen faced with a society-threatening epidemic, a state may implement emergency measures that curtail constitutional rights so long as the measures have at least some "real or substantial relation" to the public health crisis and are not "beyond all question, a plain, palpable invasion of rights secured by the fundamental law." *Jacobson*, 197 U.S. at 31. Courts may ask whether the state's emergency measures lack basic exceptions for "extreme cases," and whether the measures are pretextual—that is, arbitrary or oppressive. *Id.* at 38. At the same time, however, courts may not second-guess the wisdom or efficacy of the measures. *Id.* at 28, 30.

In re Abbott, 2020 WL 1685929, at *7 (cleaned up).

We also articulated how the *Jacobson* framework would apply to the *Casey* undue-burden analysis. *Id.* at *11 (discussing *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992)). We explained that this analysis "ask[s] whether GA-09 imposes burdens on abortion that 'beyond question' exceed its

benefits in combating the epidemic Texas now faces." *Id.* (quoting *Jacobson*, 197 U.S. at 31). We explained further that this analysis would "require[] careful parsing of the evidence," and we noted some of the conflicting evidence in the record. *Id.* But we emphasized that "[t]hese are issues that the parties may pursue at the preliminary injunction stage, where Respondents will bear the burden to prove, by a clear showing, that they are entitled to relief . . . in any particular circumstance." *Id.* at *12 (cleaned up).

The day following our mandamus, April 8, 2020, the district court did the following: (1) it vacated its March 30 TRO (Doc. 54); (2) it cancelled the telephonic preliminary injunction hearing previously scheduled for April 13 (Doc. 54); and (3) it ordered the parties to confer and propose a status report before April 15 setting out the parties' agreement on procedures and a schedule for a new preliminary injunction hearing on a yet-unannounced date (Doc. 58).

Also on April 8, plaintiffs filed in the district court a new application for TRO supported only by one additional declaration (Doc. 56). The next day, April 9, the district court—without allowing defendants either to file a pleading or to submit evidence in opposition to the TRO application—entered an order granting plaintiffs a TRO (Doc. 63). The new TRO enjoins all defendants from enforcing GA-09 against Plaintiffs or their agents in the following ways: (1) it enjoins enforcement of GA-09 "as a categorical ban on all abortions provided by Plaintiffs"; (2) it enjoins enforcement as to providing "medication abortions"; (3) it enjoins enforcement as to providing "procedural abortion[s] to any patient who, based on the treating physicians' medical judgment, would be more than 18 weeks LMP ["last menstrual period"] on April 22, 2020, and likely unable to reach an ambulatory surgical center in Texas or to obtain abortion care"; and, finally (4) it enjoins enforcement as to providing "procedural abortion[s] to any patient who, based on the treating physician's medical judgment, would

be past the legal limit for an abortion in Texas—22 weeks LMP—on April 22, 2020." (Doc. 63, at 14–15).

Texas officials have now filed a petition for writ of mandamus seeking vacatur of the April 9 TRO, as well as an emergency motion for stay of the TRO and a temporary administrative stay of the TRO.

IT IS ORDERED that the motion for temporary administrative stay of the district court's order of April 9, 2020 (Doc. 63) is GRANTED, until further order of this court, to allow sufficient time to consider the mandamus petition and emergency stay motion. This stay operates against the April 9 TRO in all respects EXCEPT that part of the TRO applying to "any patient who, based on the treating physician's medical judgment, would be past the legal limit for an abortion in Texas—22 weeks LMP—on April 22, 2020" (Doc. 63, at 15). Our stay does not operate against that part of the April 9 TRO.*

IT IS FURTHER ORDERED that plaintiffs-respondents be directed to file a response to the emergency stay motion no later than Saturday, April 11, 2020, at 8:00 p.m. Any reply by petitioners is due no later than Monday, April 13, 2020, at noon.

IT IS FURTHER ORDERED that plaintiffs-respondents be directed to file a response to the petition for writ of mandamus no later than Tuesday, April 14, 2020, at 2:00 p.m. Any reply by petitioners is due no later than Wednesday, April 15, 2020, at 2:00 p.m.

* Judge Dennis dissents, in part, because he would not stay any part of the district court's April 9 TRO.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, PLANNED PARENTHOOD OF GREATER TEXAS SURGICAL HEALTH SERVICES, PLANNED PARENTHOOD SOUTH TEXAS SURGICAL CENTER, WHOLE WOMAN'S HEALTH, WHOLE WOMAN'S HEALTH ALLIANCE, SOUTHWESTERN WOMEN'S SURGERY CENTER, BROOKSIDE WOMEN'S MEDICAL CENTER PA D/BA BROOKSIDE WOMEN'S HEALTH CENTER AND AUSTIN'S WOMEN'S HEALTH CENTER, AND ROBIN WALLACE, M.D., M.A.S., PLAINTIFFS,	§	
V.	§	CAUSE NO. A-20-CV-323-LY
GREG ABBOTT, GOVERNOR OF TEXAS, KEN PAXTON, ATTORNEY GENERAL OF TEXAS, PHIL WILSON ACTING EXECUTIVE COMMISSIONER OF THE TEXAS HEALTH AND HUMAN SERVICES COMMISSION, STEPHEN BRINT CARLTON, EXECUTIVE DIRECTOR OF THE TEXAS MEDICAL BOARD, KATHERINE A. THOMAS, EXECUTIVE DIRECTOR OF THE TEXAS BOARD OF NURSING, EACH IN THEIR OFFICIAL CAPACITY, AND MARGARET MOORE, DISTRICT ATTORNEY FOR TRAVIS COUNTY, JOE GONZALES, CRIMINAL DISTRICT ATTORNEY FOR BEXAR COUNTY, JAIME ESPARZA, DISTRICT ATTORNEY FOR EL PASO COUNTY, JOHN CREUZOT, DISTRICT	§	

ATTORNEY FOR DALLAS COUNTY,	§
SHAREN WILSON, CRIMINAL	§
DISTRICT ATTORNEY TARRANT	§
COUNTY, RICARDO RODRIGUEZ, JR.,	§
CRIMINAL DISTRICT ATTORNEY	§
FOR HIDALGO COUNTY, BARRY	§
JOHNSON, CRIMINAL DISTRICT	§
ATTORNEY FOR MCLENNAN	§
COUNTY, KIM OGG, CRIMINAL	§
DISTRICT ATTORNEY FOR HARRIS	§
COUNTY, AND BRIAN MIDDLETON	§
CRIMINAL DISTRICT ATTORNEY	§
FOR FORT BEND COUNTY, EACH IN	§
THEIR OFFICIAL CAPACITY,	§
DEFENDANTS.	§

ORDER GRANTING PLAINTIFFS' SECOND MOTION FOR A TEMPORARY RESTRAINING ORDER

Before the court is Plaintiffs' Second Motion for a Temporary Restraining Order and Memorandum in Support (Dkt. #56). Having considered the motion, the evidence in the record, the legal arguments made by all parties to date, and the opinion, order, and writ of mandamus issued by the United States Court of Appeals for the Fifth Circuit April 7, 2020, *In re Abbott*, No. 20-50264 2020 WL 1685929 (5th Cir. April 7, 2020), the court again considers whether Plaintiffs are entitled to temporary relief limiting the scope of Executive Order GA-09 issued by the governor of Texas on March 22, 2020.

Accompanying Plaintiffs' motion are proposed findings of fact and conclusions of law. The proposed findings and conclusions carefully and painstakingly track the evidence before the court regarding both of Plaintiffs' motions for temporary relief and the applicable law. The court has reviewed and considered these proposed findings and conclusions and determined that they are, in

substantial part, accurate and in concurrence with court's own review of the evidence and the law. The court will, therefore, adopt the bulk of the proposed findings and conclusions as its own.

The court makes the following findings of fact:

1. On March 13, 2020, the United States declared a state of emergency and the State of Texas declared a state of disaster related to the COVID-19 pandemic. *See* Proclamation by the Governor of the State of Texas (Mar. 13, 2020);[1] Proclamation No. 9994, 85 Fed. Reg. 15,337, 2020 WL 1272563 (Mar. 13, 2020).

2. On March 22, 2020, the governor issued an executive order barring "all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician." Executive Order GA-09, "Relating to hospital capacity during the COVID-19 disaster" (March 22, 2020) ("Executive Order") at 3.[2] The Executive Order further states that procedures that, "if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster" are exempt from the order. *Id.* The Executive Order remains in effect until 11:59 PM on April 21, 2020, unless the governor rescinds or modifies it. *Id.*

3. Federal officials and medical professionals expect the pandemic to last well beyond April 21, 2020. Schutt-Aine Decl. ¶ 40. This court likewise expects the pandemic to last beyond April 21.

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[1] *Available* at https://gov.texas.gov/uploads/files/press/DISASTER_covid19_disaster_proclamation_IMAGE_03-13-2020.pdf.

[2] *Available* at https://gov.texas.gov/uploads/files/press/EO-GA_09_COVID19_hospital_capacity_IMAGE_03-22-2020.pdf.

The current shortage of personal protective equipment ("PPE") is expected to continue for the next three to four months. Sharfstein Decl. ¶ 13.

4. Failure to comply with the Executive Order is a criminal offense punishable by a fine of up to $1,000, confinement in jail for up to 180 days, or both. Executive Order at 3 (citing Tex. Gov't Code § 418.173). Violation of the Executive Order may also give rise to disciplinary action against licensed health-care providers by the Texas Health and Human Services Commission, the Texas Medical Board, and the Texas Board of Nursing. *See* 25 Tex. Admin. Code §§ 139.32(b)(6), 135.24(a)(1)(F); 22 Tex. Admin. Code § 185.17(11); Tex. Occ. Code Ann. §§ 164.051(a)(2)(B), (a)(6); 301.452(b)(3), (B)(10).

5. On March 23, 2020, the Texas Attorney General issued a press release titled "Health Care Professionals and Facilities, Including Abortion Providers, Must Immediately Stop All Medically Unnecessary Surgeries and Procedures to Preserve Resources to Fight Covid-19 Pandemic." The press release states that providing any abortion care (other than for an immediate medical emergency) would violate the Executive Order and warned that "[t]hose who violate the governor's order will be met with the full force of the law."

6. On March 24, 2020, the Texas Medical Board ("Medical Board") adopted an emergency rule ("Emergency Rule") to enforce the Executive Order. Under pre-existing law, the Medical Board can temporarily suspend or restrict a physician's license if the physician's "continuation in practice would constitute a continuing threat to the public welfare." 22 Tex. Admin. Code § 187.57(b). The Emergency Rule expands this basis for discipline to include "performance of a non-urgent elective surgery or procedure" and incorporates the terms of the Executive Order, requiring all licensed health-

care professionals to postpone all surgeries and procedures that are not immediately necessary. 22 Tex. Admin. Code § 187.57 (emergency regulation adopted Mar. 23, 2020).[3]

7. On March 29, 2020, the Medical Board published updated guidance regarding the scheduling of elective surgeries and procedures in light of the Executive Order. Tex. Med. Bd., Updated Texas Medical Board [] Frequently Asked Questions (FAQs) Regarding Non-Urgent Elective Surgeries and Procedures During Texas Disaster Declaration for COVID-19 Pandemic (Mar. 29, 2020) ("Medical Board Guidance").[4] The Medical Board explained that postponing non-urgent elective cases would preserve PPE, ventilator availability, and [intensive-care-unit] beds." It defined "urgent or elective urgent" procedures as those where "there is a risk of patient deterioration or disease progression likely to occur if the procedure is not undertaken or is significantly delayed." The Medical Board noted that "the prohibition does not apply to office-based visits without surgeries or procedures." Further, the Medical Board explained that "[a] 'procedure' does not include physical examinations, non-invasive diagnostic tests, the performing of lab tests, or obtaining specimens to perform laboratory tests."

8. The attorney general's interpretation of the Executive Order, which has been adopted by the State Defendants,[5] creates a credible threat of enforcement against Plaintiffs and their agents for the provision of any abortion. This has had a profound chilling effect on the provision of abortion

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[3] *Available* at https://tinyurl.com/v4pz99u.

[4] *Available* at http://www.tmb.state.tx.us/idl/59C97062-84FA-BB86-91BF-F9221E4DEF17.

[5] Defendants Greg Abbott, Governor of Texas, Ken Paxton, Attorney General of Texas, Phil Wilson, Acting Executive Commissioner of the Texas Health and Human Services Commission, Stephen Brint Carlton, Executive Director of the Texas Medical Board, Katherine A. Thomas, Executive Director of the Texas Board of Nursing, each in their official capacity, are referred to as "State Defendants."

care in Texas. Plaintiffs and their agents have ceased providing nearly all abortion care as a result. Barraza Decl. ¶ 15; Dewitt-Dick Decl. ¶ 8; Ferrigno Decl. ¶¶ 25–28; Hagstrom Miller ¶¶ 26–28; Klier Decl. ¶ 17; Lambrecht Decl. ¶¶ 18–20; Schutt-Aine ¶¶ 32–34; Wallace Decl. ¶ 9.

9. Plaintiffs use two methods of providing an abortion: medication abortion and procedural abortion. Schutt-Aine Decl. ¶ 12.

10. Medication abortion is not a surgery or procedure. It involves the patient ingesting a combination of two pills: mifepristone and misoprostol. Schutt-Aine Decl. ¶ 13. The patient takes the mifepristone in the health center and then, typically 24 to 48 hours later, takes the misoprostol at a location of their choosing, most often at their home, after which they expel the contents of the pregnancy in a manner similar to a miscarriage. Schutt-Aine Decl. ¶ 13. Texas law restricts this method to the first 10 weeks of pregnancy as measured from the first day of a pregnant woman's last menstrual period ("LMP"). Tex. Health & Safety Code § 171.063. Plaintiffs provide medication abortion up to the 10-week limit.

11. Despite sometimes being referred to as "surgical abortion," procedural abortion is not what is commonly understood to be "surgery"; it involves no incision, no need for general anesthesia, and no requirement of a sterile field. Schutt-Aine Decl. ¶ 16. Early in pregnancy, procedural abortions are performed using a technique called aspiration, in which a clinician uses gentle suction from a narrow, flexible tube to empty the contents of the patient's uterus. Schutt-Aine Decl. ¶ 16. Beginning around 15 weeks LMP, the clinician generally must use instruments to complete the procedure, a technique called dilation and evacuation ("D&E"). Later in the second trimester of pregnancy, the clinician may begin cervical dilation the day before the procedure itself, resulting in a two-day procedure. Schutt-Aine Decl. ¶ 16. Plaintiffs provide procedural abortion in both the first and second

trimester. Procedural abortions may not be performed in an abortion clinic after 18 weeks LMP. Tex. Health & Safety Code 171.004. At that point, outpatient procedural abortions may only be performed at an ambulatory surgery center ("ASC"), *id.*, but there are no ASCs that provide abortion care outside of Texas's four largest metropolitan areas, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2316 (2016).

12. Absent exceptional circumstances, Texas law prohibits abortion care altogether after 22 weeks LMP. *See* Tex. Health & Safety Code § 171.044.

13. Abortion patients rarely require hospitalization. Ferrigno Decl. ¶ 14; Hagstrom Miller Decl. ¶ 17; Schutt-Aine Decl. ¶ 12; *Whole Woman's Health*, 136 S. Ct. at 2311.

14. Although some medication abortions require a follow-up aspiration procedure, the number of those cases is exceedingly small and can generally be handled in an outpatient setting. Levison Decl. ¶ 9; Schutt-Aine Decl. ¶ 12.

15. Providing medication abortion does not require the use of any PPE. Barraza Decl. ¶ 7; Dewitt-Dick Decl. ¶ 19; Ferrigno Decl. ¶ 10; Hagstrom Miller Decl. ¶ 13; Lambrecht Decl. ¶ 12; Klier Decl. ¶ 11; Schutt-Aine Decl. ¶ 25; Wallace Decl. ¶ 12.

16. Texas law requires an in-person consultation between patient and provider, which must include an ultrasound examination, before every abortion. *See* Tex. Health & Safety Code § 171.012(a)(4), (b). For patients who reside within 100 miles of the facility where the abortion will be performed, the consultation must occur at least 24 hours prior to the abortion procedure. *See id.* According to the Medical Board, "non-invasive diagnostic tests" such as ultrasounds are not procedures, and the prohibition contained in the Executive Order "does not apply to office-based visits without surgery or procedures." Medical Board Guidance. In any event, pre-procedure

ultrasound examinations require minimal PPE. Use of PPE is not required at all for abdominal ultrasound examinations. Ferrigno Decl. ¶ 11; Hagstrom Miller Decl. ¶ 14; Macones Decl. ¶ 14. For vaginal ultrasound examinations, doctors or ultrasound technicians typically wear only non-sterile gloves that are discarded after each scan. Ferrigno Decl. ¶ 11; Hagstrom Miller Decl. ¶ 14; Macones Decl. ¶ 14. When laboratory testing is required, technicians likewise utilize only non-sterile gloves. Hagstrom Miller Decl. ¶ 14.

17. For procedural abortion, providers may use some or all of the following PPE items, depending on the circumstances: gloves, a surgical mask, disposable protective eyewear, disposable or washable gowns, hair covers, and shoe covers. Barraza Decl. ¶ 7; Dewitt-Dick Decl. ¶ 19; Ferrigno Decl. ¶¶ 10, 12; Hagstrom Miller Decl. ¶¶ 13, 15; Klier Decl. ¶ 11; Lambrecht Decl. ¶ 12; Schutt-Aine Decl. ¶ 25; Wallace Decl. ¶ 12.

18. Following a procedural abortion, the tissue removed from a patient is examined in a pathology laboratory. Ferrigno Decl. ¶ 12; Hagstrom Miller ¶ 15. This task is typically performed by a single staff member who utilizes one washable gown per shift, either one disposable face shield per shift or one set of reusable goggles, one set of disposable shoe covers per shift, one disposable hair cap per shift, and one or more sets of non-sterile gloves. Hagstrom Miller ¶ 15. According to the Medical Board, "the performing of lab tests" is not subject to the Executive Order. Medical Board Guidance; *see also* Tex. Med. Ass'n, TMB Releases Emergency Rules: Non-Urgent Surgeries and Procedures, at 3, 6 (Mar. 29, 2020).[6]

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[6] *Available* at https://www.texmed.org/uploadedFiles/Current/2016_Public_Health/Infectious_Diseases/Emergency%20rule%20guidance%20-%203.25%20Update.pdf.

19. Abortion providers generally do not use N95 masks. Only one physician associated with Plaintiffs has used an N95 mask since the beginning of the COVID-19 pandemic, and that physician has been reusing the same mask over and over. Barraza Decl. ¶ 8; Ferrigno Decl. ¶ 13; Hagstrom Miller Decl. ¶ 16; Klier Decl. ¶ 6; Lambrecht Decl. ¶ 12; Schutt-Aine Decl. ¶ 27.

20. Pregnant women prevented from accessing abortion will still require medical care. Chang Decl. ¶ 8; Levison Decl. ¶ 8; Macones Decl. ¶ 10. Consistent with recommendations from the American College of Obstetricians and Gynecologists ("ACOG") and other medical authorities for providing obstetrical care during the COVID-19 pandemic, obstetricians are generally having two in-person visits with pregnant patients during the first-trimester and more frequent in-person visits during later trimesters. Chang Decl. ¶ 11; Levison Decl. ¶ 19; Macones Decl. ¶¶ 9–10; Wood Decl. ¶ 11. High-risk patients, including those with diabetes or high blood pressure, must have more frequent in-person visits. Chang Decl. ¶ 10; Levison Decl. ¶ 14; Macones Decl. ¶¶ 7, 10; Wood Decl. ¶¶ 11–12. Urine specimens are generally collected and tested at each in-person visit, and blood is sometimes collected and tested also. Chang Decl. ¶ 12; Levison Decl. ¶ 13; Macones Decl. ¶ 11; Wood Decl. ¶ 11. Additionally, obstetricians are generally performing at least one ultrasound during the first trimester and another one at 20 weeks LMP. Chang Decl. ¶¶ 11–12; Macones Decl. ¶ 12; Wood Decl. ¶ 14. High-risk patients will require more frequent ultrasounds. Macones Decl. ¶ 12; Wood Decl. ¶ 14.

21. Because individuals with ongoing pregnancies require more in-person healthcare, including lab tests and ultrasounds, at each stage of pregnancy than individuals who have previability abortions, delaying access to abortion will not conserve PPE. Levison Decl. ¶¶ 12–14; Macones Decl. ¶ 20; Schutt-Aine Decl. ¶ 26.

22. Individuals with ongoing pregnancies are more likely to seek treatment in a hospital—for a variety of conditions—than individuals who have pre-viability abortions. Therefore, delaying access to abortion will not conserve hospital resources. Levison Decl. ¶¶ 8–11; Macones Decl. ¶ 19; Schutt-Aine Decl. ¶ 26; *Whole Woman's Health*, 136 S. Ct. at 2311.

23. Individuals who are delayed past the legal limit for abortion will have to deliver babies. Delivery generally takes place in a hospital and requires extensive use of PPE. Thus, requiring patients to carry unwanted pregnancies to term will not conserve PPE or hospital resources. Chang Decl. ¶¶ 16–17; Levison Decl. ¶¶ 9, 15–17; Macones Decl. ¶ 18; Schutt-Aine Decl. ¶ 26.

24. Physicians are continuing to provide obstetrical and gynecological procedures comparable to abortion in PPE use or time-sensitivity, based on their professional medical judgment. *See* Chang Decl. ¶ 24; Levison Decl. ¶ 18.

25. The inability to obtain abortion care in Texas as a result of the Executive Order is causing individuals with unwanted pregnancies who have the ability to travel to go to other states to obtain abortions. The record shows that these individuals are traveling by both car and airplane to places as far away as Colorado and Georgia. Doe Decl. ¶¶ 15–22; Johnson Decl. ¶¶ 8–10; Nguyen Decl. ¶ 17; Ward Decl. ¶¶ 12-14. This long-distance travel increases an individual's risk of contracting COVID-19. Bassett Decl. ¶¶ 7–8; Schutt-Aine Decl. ¶ 37; Sharfstein Decl. ¶ 10; Doe Decl. ¶ 18. The record shows that patients traveling to other states for abortion care include patients seeking medication abortion. Doe Decl. ¶¶ 9, 19–22.

26. Plaintiffs have turned away hundreds of patients seeking abortion care, and will turn away hundreds more, absent entry of a temporary restraining order. Barraza Decl. ¶¶ 6, 15; Dewitt-Dick

Decl. ¶ 8; Ferrigno Decl. ¶¶ 26–28; Hagstrom Miller Decl. ¶¶ 27–28; Johnson Decl. ¶ 4; Klier Decl. ¶ 17; Lambrecht Decl. ¶¶ 18–20; Nguyen Decl. ¶ 8; Schutt-Aine Decl. ¶¶ 33–34; Wallace Decl. ¶ 9.

27. There will be significant pent-up need for abortion care when the Executive Order expires. It will take Plaintiffs weeks to resolve the resulting backlog of patients, meaning that a significant number of patients will face additional delays in accessing abortion even after the Executive Order's now month-long duration expires. Ferrigno Decl. ¶ 29; Hagstrom Miller Decl. ¶ 29; Johnson Decl. ¶ 12; Nguyen Decl. ¶ 23.

28. Patients delayed past 10 weeks LMP are no longer eligible for a medication abortion in Texas. *See* Tex. Health & Safety Code § 171.063(a)(2). Patients delayed past 14 to 16 weeks LMP are no longer eligible for an aspiration abortion, and must instead have a D&E, which is a lengthier and more complex procedure. Ferrigno Decl. ¶ 35; Hagstrom Miller Decl. ¶ 34; Lambrecht Decl. ¶ 18; Schutt-Aine Decl. ¶¶ 16, 39. Patients who are delayed past 18 weeks LMP are no longer eligible for an abortion at an abortion clinic in Texas and must obtain care from an ASC. *See* Tex. Health & Safety Code § 171.004. Patients delayed past 22 weeks LMP are no longer eligible to obtain an abortion in Texas at all, absent exceptional circumstances. *See* Tex. Health & Safety Code § 171.044. Declarations in the record demonstrate that some patients have *already* exceeded the gestational age limit to obtain an abortion in Texas while the Executive Order has been in place. Hagstrom Miller Decl. ¶ 27; Johnson Decl. ¶ 10; Nguyen Decl. ¶¶ 7–8, 11; Ward Decl. ¶¶ 12-13, 16.

29. The health risks associated with both pregnancy and abortion increase with gestational age. Dewitt-Dick Decl. ¶ 22; Ferrigno Decl. ¶ 36; Hagstrom Miller Decl. ¶ 35; Schutt-Aine Decl. ¶ 22; Macones Decl. ¶ 8. As ACOG and other well-respected medical professional organizations have observed, specifically in relation to the COVID-19 pandemic, abortion "is an essential component of

comprehensive health care" and "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks [to patients] or potentially make it completely inaccessible." ACOG et al., *Joint Statement on Abortion Access During the COVID-19 Outbreak* (Mar. 18, 2020);[7] Schutt-Aine Decl. ¶ 22; Sharfstein Decl. ¶ 8.

30. In addition to increasing health risks, delayed access to abortion imposes financial and emotional costs on people with unwanted pregnancies. The cost of an abortion increases with gestational age. Dewitt-Dick Decl. ¶ 22; Ferrigno Decl. ¶ 36; Hagstrom Miller Decl. ¶ 35; Schutt-Aine Decl. ¶ 39. Women with ongoing pregnancies must cope with the physical symptoms of pregnancy, which often include morning sickness and weight gain; must struggle to conceal their pregnancies from abusive partners or family members; and must deal with the stress and anxiety of not knowing when—or if—they will be able to obtain an abortion. Connor Decl. ¶ 11; Ferrigno Decl. ¶ 34; Hagstrom Miller Decl. ¶ 33; Nguyen Decl. ¶¶ 10–14; Northcutt Decl. ¶¶ 5–6; Ward Decl. ¶¶ 16-17.

31. The court incorporates by reference the findings of fact contained in the court's March 30, 2020 Order Granting Plaintiffs' Request for Temporary Restraining Order. *Planned Parenthood Center for Choice v. Abbott*, 1:20-CV-323-LY (W.D. Tex. Mar. 30, 2020).

The court makes the following conclusions of law:

1. Plaintiffs have standing to bring their claim and a justiciable controversy exists. *See In re Abbott*, No. 20-50264, slip op. at 8 n.17, 2020 WL 1685929 (5th Cir. Apr. 7, 2020). For purposes of sovereign immunity, the governor and attorney general likely have "some connection with the

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[7] *Available* at https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortionaccess-during-the-covid-19-outbreak.

the governor, Executive Order at 3, consistent with the governor's statutory authority, Tex. Gov't Code Ann. § 418.012. Similarly, the attorney general has the authority to prosecute Plaintiffs and their agents, at the request of local prosecutors, for alleged violations of the Executive Order, Tex. Gov't Code Ann. § 402.028(a), and he has publicly threatened enforcement against abortion providers in particular.

2. Plaintiffs are entitled to the requested temporary restraining order. In particular, the court concludes that Plaintiffs are likely to succeed on the merits of their substantive due-process claim because, based on the court's findings of fact, it is beyond question that the Executive Order's burdens outweigh the order's benefits as applied to Plaintiffs' provision of (1) medication abortion; and (2) procedural abortion where, in the treating physician's medical judgment, the patient would otherwise be denied access to abortion entirely because (a) the patient's pregnancy would reach 22 weeks LMP by April 21, 2020; or (b) the patient's pregnancy would reach 18 weeks LMP by April 21, 2020, thus requiring abortion care at an ASC and, in the judgment of the treating physician, the patient is unlikely to be able to obtain an abortion at an ASC before the patient's pregnancy reaches the 22-week cutoff. The court therefore concludes that application of the Executive Order to these categories of abortion care violates the standards set forth in both *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), and *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11 (1905).

To women in these categories, the Executive Order is an absolute ban on abortion. When a temporary delay reaches 22 weeks LMP, the ban is not temporary, it is absolute. A ban within a limited period becomes a total ban when that period expires. As a minimum, this is an undue burden on a woman's right to a previability abortion.

limited period becomes a total ban when that period expires. As a minimum, this is an undue burden on a woman's right to a previability abortion.

3. Plaintiffs and their patients will suffer irreparable harm in the absence of a temporary restraining order; the balance of equities favors Plaintiffs; and entry of a temporary restraining order serves the public interest. In particular, the record demonstrates that entry of a temporary restraining order to restore abortion access would *serve* the State's interest in public health. *See, e.g.*, Bassett Decl. ¶¶ 6–8; Levison Decl. ¶¶ 20–23; Sharfstein Decl. ¶¶ 9–12.

4. The court incorporates by reference the conclusions of law contained in the court's March 30, 2020 Order Granting Plaintiffs' Request for Temporary Restraining Order. *Planned Parenthood Center of Choice*, No. 1:20-CV-323-LY (W.D. Tex. Mar. 30, 2020).

Therefore,

IT IS ORDERED that Plaintiffs' Second Motion for Temporary Restraining Order (Dkt. #56), filed April 8, 2020, is **GRANTED**.

IT IS FURTHER ORDERED that Defendants and their employees, agents, successors, and all others acting in concert or participating with them are **TEMPORARILY RESTRAINED** from enforcing Executive Order GA-09, "Relating to hospital capacity during the COVID-19 disaster," and the Texas Medical Board's emergency amendment to Title 22 Texas Administrative Code section 187.57, as a categorical ban on all abortions provided by Plaintiffs.

IT IS FURTHER ORDERED that Defendants and their employees, agents, successors, and all others acting in concert or participating with them, are **TEMPORARILY RESTRAINED** from enforcing Executive Order GA-09 and the Emergency Rule against Plaintiffs or agents of Plaintiffs who provide medication abortions.

IT IS FURTHER ORDERED that Defendants and their employees, agents, successors, and all others acting in concert or participating with them, are **TEMPORARILY RESTRAINED** from enforcing Executive Order GA-09 and the Emergency Rule against Plaintiffs or agents of Plaintiffs who provide a procedural abortion to any patient who, based on the treating physician's medical judgment, would be more than 18 weeks LMP on April 22, 2020, and likely unable to reach an ambulatory surgical center in Texas or to obtain abortion care.

IT IS FURTHER ORDERED that Defendants and their employees, agents, successors, and all others acting in concert or participating with them, are **TEMPORARILY RESTRAINED** from enforcing Executive Order GA-09 and the Emergency Rule against Plaintiffs or agents of Plaintiffs who provide a procedural abortion to any patient who, based on the treating physician's medical judgment, would be past the legal limit for an abortion in Texas—22 weeks LMP—on April 22, 2020.

IT IS FURTHER ORDERED that this Temporary Restraining Order shall expire on April 19, 2020, at 4:25pm. This order may be extended for good cause, pursuant to Federal Rule of Civil Procedure 65.

Pursuant to an Agreed Stipulation for Non-Enforcement Pending Final Resolution, Attorneys Fees and Costs filed March 28, 2020 (Clerk's Dkt. #25) this order does not apply to Defendant Brian Middleton, Criminal District Attorney for Fort Bend County.

Plaintiffs shall not be required to post a bond. *See Kaepa, Inc. v. Achilles Corp.*, 76 F.3d 624, 628 (5th Cir. 1996).

This court's April 8, 2020 Order (Dkt. #58) is not affected by this order, and the parties shall continue to comply with the April 8 order.

SIGNED this 9th day of April, 2020 at 4:25 p.m.

LEE YEAKEL
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

United States Court of Appeals
Fifth Circuit

FILED
April 7, 2020

Lyle W. Cayce
Clerk

No. 20-50264

In re: GREG ABBOTT, in his official capacity as Governor of Texas; KEN PAXTON, in his official capacity as Attorney General of Texas; PHIL WILSON, in his official capacity as Acting Executive Commissioner of the Texas Health and Human Services Commission; STEPHEN BRINT CARLTON, in his official capacity as Executive Director of the Texas Medical Board; KATHERINE A. THOMAS, in her official capacity as the Executive Director of the Texas Board of Nursing,

Petitioners

Petition for a Writ of Mandamus to
the United States District Court
for the Western District of Texas

Before DENNIS, ELROD, and DUNCAN, Circuit Judges.

STUART KYLE DUNCAN, Circuit Judge:

To preserve critical medical resources during the escalating COVID-19 pandemic, on March 22, 2020, the Governor of Texas issued executive order GA-09, which postpones non-essential surgeries and procedures until 11:59 p.m. on April 21, 2020. Reading GA-09 as an "outright ban" on pre-viability abortions, on March 30 the district court issued a temporary restraining order ("TRO") against GA-09 as applied to abortion procedures. At the request of Texas officials, we temporarily stayed the TRO while considering their petition for a writ of mandamus directing vacatur of the TRO. We now grant the writ.

The "drastic and extraordinary" remedy of mandamus is warranted for several reasons. *In re JPMorgan Chase & Co.*, 916 F.3d 494, 499 (5th Cir. 2019) (citation omitted).

First, the district court ignored the framework governing emergency public health measures like GA-09. *See Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11 (1905). "[U]nder the pressure of great dangers," constitutional rights may be reasonably restricted "as the safety of the general public may demand." *Id.* at 29. That settled rule allows the state to restrict, for example, one's right to peaceably assemble, to publicly worship, to travel, and even to leave one's home. The right to abortion is no exception. *See Roe v. Wade*, 410 U.S. 113, 154 (1973) (citing *Jacobson*); *Planned Parenthood v. Casey*, 505 U.S. 833, 857 (1992) (same); *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007) (same).[1]

Second, the district court's result was patently wrong. Instead of applying *Jacobson*, the court wrongly declared GA-09 an "outright ban" on pre-viability abortions and exempted all abortion procedures from its scope. The court also failed to apply *Casey*'s undue-burden analysis and thus failed to balance GA-09's temporary burdens on abortion against its benefits in thwarting a public health crisis.

Third, the district court usurped the state's authority to craft emergency health measures. Instead, the court substituted its own view of the efficacy of applying GA-09 to abortion. But "[i]t is no part of the function of a court" to

[1] Our dissenting colleague suggests our decision "follows not because of the law or facts, but because of the subject matter of this case." Dissent at 3. That is wrong. As explained below, *infra* III.A.1, *Jacobson* governs a state's emergency restriction of *any* individual right, not only the right to abortion. The same analysis would apply, for example, to an emergency restriction on gathering in large groups for public worship during an epidemic. *See Prince v. Massachusetts*, 321 U.S. 158, 166–67 (1944) ("The right to practice religion freely does not include liberty to expose the community . . . to communicable disease.").

decide which measures are "likely to be the most effective for the protection of the public against disease." *Jacobson*, 197 U.S. at 30.

In sum, given the extraordinary nature of these errors, the escalating spread of COVID-19, and the state's critical interest in protecting the public health, we find the requirements for issuing the writ satisfied. *See Cheney v. U.S. Dist. Court for Dist. of Columbia*, 542 U.S. 367, 380–81 (2004).

We emphasize the limits of our decision, which is based only on the record before us. The district court has scheduled a telephonic preliminary injunction hearing for April 13, 2020, when all parties will presumably have the chance to present evidence on the validity of applying GA-09 in specific circumstances. The district court can then make targeted findings, based on competent evidence, about the effects of GA-09 on abortion access. Our overriding consideration here, however, is that those proceedings adhere to the controlling standards, established by the Supreme Court over a century ago, for adjudging the validity of emergency measures like the one before us.

Accordingly, we grant a writ of mandamus directing the district court to vacate its TRO of March 30, 2020.

I.

As all are painfully aware, our nation faces a public health emergency caused by the exponential spread of COVID-19, the respiratory disease caused by the novel coronavirus SARS-CoV-2. As of April 6, 2020, over 330,000 cases have been confirmed across the United States, with over 8,900 dead.[2] The virus is "spreading very easily and sustainably"[3] throughout the country, with cases

[2] Centers for Disease Control and Prevention, Coronavirus Disease 2019 (COVID-19): Cases in the U.S., https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html (last visited April 6, 2020).

[3] Centers for Disease Control and Prevention, Coronavirus Disease 2019 (COVID-19): How COVID-19 Spreads, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html (last visited April 6, 2020).

confirmed in all fifty states, the District of Columbia, and several territories.[4] Over the past two weeks, confirmed cases in the United States have increased by over 2,000%.[5] Federal projections estimate that, even with mitigation efforts, between 100,000 and 240,000 people in the United States could die.[6] In Texas, the virus has spread rapidly over the past two weeks and is predicted to continue spreading exponentially in the coming days and weeks.

On March 13, 2020, the President declared a national state of emergency, and the Governor of Texas declared a state of disaster.[7] Six days later, the Texas Health and Human Services Executive Commissioner declared a public health disaster because the virus "poses a high risk of death to a large number of people and creates a substantial risk of public exposure because of the disease's method of transmission and evidence that there is community spread in Texas."[8] As the district court in this case acknowledged, "Texas faces it[s] worst public health emergency in over a century."

The surge of COVID-19 cases causes mounting strains on healthcare systems, including critical shortages of doctors, nurses, hospital beds, medical

[4] Centers for Disease Control and Prevention, Coronavirus Disease 2019 (COVID-19): Cases in the U.S., https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html (last visited April 6, 2020).

[5] *Id.* On March 19, 2020, the CDC reports that there were 15,219 diagnosed cases in the United States, excluding cases among persons repatriated to the United States from China and Japan. *Id.* By April 6, 2020, the number of cases reported has risen to 330,891. *Id.*

[6] Rick Noack, et al., *White House task force projects 100,000 to 240,000 deaths in U.S., even with mitigation efforts*, WASHINGTON POST (Mar. 31, 2020), https://www.washingtonpost.com/world/2020/03/31/coronavirus-latest-news/.

[7] *See* Proc. No. 9994, 85 Fed. Reg. 15,337, 2020 WL 1272563 (Mar. 13, 2020); Tex. Proc. of Mar. 13, 2020, https://gov.texas.gov/uploads/files/press/DISASTER_covid19_disaster_proclamation_IMAGE_03-13-2020.pdf.

[8] Tex. Proc. of Mar. 19, 2020, https://gov.texas.gov/uploads/files/press/DECLARATION_of_public_health_disaster_Dr_Hellerstedt_03-19-2020.pdf.

equipment, and personal protective equipment ("PPE").[9] The executive order at issue here, GA-09, responds to this crisis. Issued by the Governor of Texas on March 22, 2020, GA-09 applies to all licensed healthcare professionals and facilities in Texas and requires that they:

> postpone all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician.[10]

Importantly, the order "shall not apply to any procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster."[11] Failure to comply with the order may result in administrative or criminal penalties, including "a fine not to exceed $1,000, confinement in jail for a term not to exceed 180 days, or both."[12] The order automatically expires after 11:59 p.m. on April 21, 2020, but can be modified, amended, or superseded.

[9] Centers for Disease Control and Prevention, Coronavirus Disease 2019 (COVID-19): Strategies for Optimizing the Supply of Facemasks, https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html (last visited April 6, 2020); Megan L. Ranney, M.D., M.P.H., et al., *Critical Supply Sources—The Need for Ventilators and Personal Protective Equipment during the COVID-19 Pandemic*, NEW ENG. J. OF MED. (Mar. 25, 2020), https://www.nejm.org/doi/full/10.1056/NEJMp2006141?query=featured_coronavirus.

[10] Tex. Exec. Order No. GA-09 (Mar. 22, 2020), https://gov.texas.gov/uploads/files/press/EO-GA_09_COVID-19_hospital_capacity_IMAGE_03-22-2020.pdf.

[11] Tex. Exec. Order No. GA-09 (Mar. 22, 2020), https://gov.texas.gov/uploads/files/press/EO-GA_09_COVID-19_hospital_capacity_IMAGE_03-22-2020.pdf.

[12] Tex. Exec. Order No. GA-09 (Mar. 22, 2020), https://gov.texas.gov/uploads/files/press/EO-GA_09_COVID-19_hospital_capacity_IMAGE_03-22-2020.pdf (citing Tex. Gov't Code § 418.173); *see also* 25 Tex. Admin. Code § 139.32(b)(6); 25 Tex. Admin. Code § 135.24(a)(1)(F); 22 Tex. Admin. Code § 185.17(11); 22 Tex. Admin. Code § 185.57(c) (Mar. 23, 2020); Tex. Occ. Code § 164.051(a)(2); Tex. Occ. Code § 164.051(a)(6); Tex. Occ. Code § 301.452(b)(3); Tex. Occ. Code § 301.452(b)(10).

On March 25, 2020, various Texas abortion providers[13] ("Respondents") filed suit in federal district court against multiple Texas officials, including the Governor, Attorney General, three state health officials, and nine District Attorneys ("Petitioners"[14]). Respondents brought substantive due process and equal protection claims and sought to enjoin enforcement of GA-09, as well as the Texas Medical Board's Emergency Rule implementing the order. *See* 22 Tex. Admin. Code § 187.57(c) (Mar. 23, 2020). Simultaneously, Respondents sought a temporary restraining order ("TRO") or a preliminary injunction, based only on their due process claim. Following a March 26 conference call, the district court gave Petitioners until March 30 at 9:00 a.m. to respond, which they did. Later that same day, the district court entered a TRO.

In the TRO, the district court agreed that "Texas faces it[s] worst public health emergency in over a century," and also that "[GA-09], as written, does not exceed the governor's power to deal with the emergency." Nonetheless, the court interpreted GA-09 as "effectively banning all abortions before viability." The court reasoned that, because "no interest" can justify such an "outright ban" on pre-viability abortions, GA-09 contravenes Supreme Court and Fifth Circuit precedent. The TRO therefore prohibits all defendants, including

[13] Plaintiffs are Texas abortion providers Planned Parenthood Center for Choice, Planned Parenthood of Greater Texas Surgical Health Services, Planned Parenthood South Texas Surgical Center, Whole Woman's Health, Whole Woman's Health Alliance, Southwestern Women's Surgery Center, Brookside Women's Medical Center PA d/b/a Brookside Women's Health Center and Austin Women's Health Center, and Robin Wallace, M.D. Plaintiffs purport to sue on behalf of themselves, their staff, physicians, nurses, and patients.

[14] Petitioners here do not include the defendant District Attorneys.

Petitioners, from enforcing GA-09 and the emergency rule "as applied to medication abortions and procedural[15] abortions." App. 267–68, 270.[16]

On the evening of March 30, 2020, Petitioners filed a petition for writ of mandamus in our court, requesting that we direct the district court to vacate the TRO. Petitioners simultaneously sought an emergency stay of the TRO, as well as a temporary administrative stay, while the court considered their request. On March 31, 2020, we temporarily stayed the TRO and set an expedited briefing schedule.

II.

Federal courts "may issue all writs necessary or appropriate in aid of their respective jurisdictions and agreeable to the usages and principles of law." 28 U.S.C. § 1651(a). That includes the writ of mandamus sought by Petitioners. *See Cheney*, 542 U.S. at 380; *In re Gee*, 941 F.3d 153, 157 (5th Cir. 2019). Mandamus is proper only in "exceptional circumstances amounting to a judicial usurpation of power or a clear abuse of discretion." *In re Volkswagen of Am., Inc.*, 545 F.3d 304, 309 (5th Cir. 2008) (en banc) (quoting *Cheney*, 542 U.S. at 380). Before prescribing this strong medicine, "we ask (1) whether the

[15] "Procedural" abortions, the term used by Respondents and the district court, refers to what are also called "surgical" abortions. *See, e.g.*, *Stenberg v. Carhart*, 530 U.S. 914, 924 (2000) (citing M. Paul et al., A Clinician's Guide to Medical and Surgical Abortion (1999)); *Gonzales v. Carhart*, 550 U.S. 124, 175 (2007) (Ginsburg, J., dissenting) (referring to "surgical abortions") (quoting *Carhart v. Ashcroft*, 331 F.Supp.2d 805, 1011 (D. Neb. 2004), *aff'd*, 413 F.3d 791 (8th Cir. 2005)); *Planned Parenthood v. Casey*, 505 U.S. 833, 969 (1992) (Rehnquist, J., concurring in the judgment in part and dissenting in part) (referring to "any other surgical procedure except abortion") (quoting *Webster v. Reproductive Health Servs.*, 492 U.S. 490, 517 (1989) (plurality opinion)); *see also*, *e.g.*, Br. for Petitioners at 33 n.64, *Planned Parenthood v. Casey*, 505 U.S. 833 (1992) (Nos. 91-744, 91-902), 1992 WL 12006398 (referring to "induced abortion" as a "surgical procedure[ ]").

[16] The TRO is scheduled to expire at 3:00 p.m. on April 13, 2020. The district court has scheduled a telephonic hearing on Plaintiffs' request for a preliminary injunction for 9:30 a.m. that same day. App. 271. Our references to "App." throughout this opinion are to the appendix to the mandamus petition. *See* ECF 3 (5th Cir. No. 20-50264).

petitioner has demonstrated that it has no other adequate means to attain the relief it desires; (2) whether the petitioner's right to issuance of the writ is clear and indisputable; and (3) whether we, in the exercise of our discretion, are satisfied that the writ is appropriate under the circumstances." *In re Itron, Inc.*, 883 F.3d 553, 567 (5th Cir. 2018) (quoting *Cheney*, 542 U.S. at 380–81) (cleaned up). "These hurdles, however demanding, are not insuperable. They simply reserve the writ for really extraordinary causes." *Gee*, 941 F.3d at 158 (cleaned up). In such a case, mandamus provides a "useful 'safety valve[]' for promptly correcting serious errors." *Mohawk Indus., Inc. v. Carpenter*, 558 U.S. 100, 111 (2009) (quoting *Digital Equipment Corp. v. Desktop Direct, Inc.*, 511 U.S. 863, 883 (1994)).

III.

Petitioners claim they satisfy all three mandamus prongs and are therefore entitled to the writ. As to the first prong, they argue mandamus is proper for obtaining relief, even from a non-appealable TRO, when the stakes are "extraordinarily time-sensitive." ECF 2 at 30–31. As to the second prong, Petitioners contend the district court "clearly and indisputably erred" by ruling that abortion is an absolute right which cannot be curtailed even in the midst of a public health emergency.[17] *Id.* at 11–24. Finally, as to the third prong,

[17] Alternatively under prong two, Petitioners assert that (1) no justiciable controversy exists as to the Governor and Attorney General because they lack authority to enforce GA-09, and (2) Respondents lack third-party standing to sue on behalf of their patients. We decline to grant relief on these grounds. First, quite apart from the Governor and Attorney General, a justiciable controversy exists as to the Petitioner health officials, who may enforce the order's administrative penalties. *See*, *e.g.*, 22 Tex. Admin. Code § 187.57(b). On remand, however, the district court should consider whether the Eleventh Amendment requires dismissal of the Governor or Attorney General because they lack any "connection" to enforcing GA-09 under *Ex parte Young*, 209 U.S. 123 (1908). *City of Austin v. Paxton*, 943 F.3d 993, 999 (5th Cir. 2019); *see also Morris v. Livingston*, 739 F.3d 740, 745–46 (5th Cir. 2014). Second, Respondents have standing to sue on their own behalf because GA-09 "directly operates" against them. *Planned Parenthood of Cen. Mo. v. Danforth*, 428 U.S. 52, 62 (1976) (cleaned up). We therefore need not consider at this time whether Respondents may sue on

Petitioners argue mandamus is proper because "[t]he longer [Respondents] are allowed to perform elective procedures—consuming scarce PPE, increasing hospitalizations, and potentially spreading the virus to countless individuals—the longer it will take to flatten the curve in Texas, meaning more illnesses, more hospitalizations, and more deaths." *Id.* at 31. We address each prong in turn, beginning with the second.

A.

We first address the second mandamus prong—whether entitlement to the writ is "clear and indisputable"—because it is central to our analysis. *See*, *e.g.*, *Volkswagen*, 545 F.3d at 311 (beginning with second prong because it "captures the essence of the disputed issue"). "In recognition of the extraordinary nature of the writ, we require more than showing that the court misinterpreted the law, misapplied it to the facts, or otherwise engaged in an abuse of discretion." *In re Lloyd's Register N. Am., Inc.*, 780 F.3d 283, 290 (5th Cir. 2015). Rather, a petitioner has a clear and indisputable right to the writ only when there has been a "usurpation of judicial power" or "a clear abuse of discretion that produces patently erroneous results." *JPMorgan Chase*, 916 F.3d at 500 (cleaned up); *see also Gee*, 941 F.3d at 159; *Lloyd's Register*, 780 F.3d at 290. Usurpation of judicial power occurs when courts act beyond their jurisdiction or fail to act when they have a duty to do so. *Will v. United States*, 389 U.S. 90, 95 (1967). But it also occurs in other situations. The Supreme Court has sanctioned use of the writ "to restrain a lower court when its actions would threaten the separation of powers by 'embarrassing the executive arm of the Government,' or result in the 'intrusion by the federal judiciary on a delicate area of federal-state relations.'" *Cheney*, 542 U.S. at 381 (citing *Will*,

behalf of their patients. We note that the Supreme Court recently granted a certiorari petition raising this third-party standing issue. *See Russo v. June Med. Servs.*, No. 18-1460.

389 U.S. at 95; *Ex parte Peru,* 318 U.S. 578, 588 (1943); *Maryland v. Soper (No. 1),* 270 U.S. 9 (1926)) (cleaned up).

We conclude Petitioners have shown "a clear and indisputable right to issuance of the writ." *Volkswagen*, 545 F.3d at 311. In issuing the TRO, the district court clearly abused its discretion by failing to apply (or even acknowledge) the framework governing emergency exercises of state authority during a public health crisis, established over 100 years ago in *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11 (1905). This extraordinary error allowed the district court to create a blanket exception for a common medical procedure—abortion—that falls squarely within Texas's generally-applicable emergency measure issued in response to the COVID-19 pandemic. This was a patently erroneous result. In addition, the court usurped the power of the governing state authority when it passed judgment on the wisdom and efficacy of that emergency measure, something squarely foreclosed by *Jacobson*.[18]

1.

In *Jacobson*, the Supreme Court considered a claim that the state's compulsory vaccination law—enacted amidst a growing smallpox epidemic in Cambridge, Massachusetts—violated the defendant's Fourteenth Amendment right "to care for his own body and health in such way as to him seems best."

[18] This case differs from *Preterm-Cleveland v. Atty. Gen. of Ohio*, No. 20-3365, 2020 WL 1673310 (6th Cir. Apr. 6, 2020), which declined to review a TRO against Ohio's non-essential-surgeries order. Ohio appealed on the basis that the TRO "threaten[ed] to inflict irretrievable harms." *Id.* at *1. Observing the TRO was "narrowly tailored" and did not permit "blanket" provision of abortions, the majority concluded that the TRO would not inflict irreparable harms and thus that it lacked jurisdiction over the appeal. *Id.* at *1–2. By contrast, here Petitioners seek not appeal but mandamus, a drastic remedy that we nonetheless find appropriate. Moreover, the TRO here is not "narrowly tailored" but exempts all abortions from GA-09. The TRO's broad sweep also distinguishes this case from recent district court decisions in Alabama and Oklahoma. *See Robinson v. Marshall*, No. 2:19cv365-MHT, 2020 WL 1659700 (M.D. Ala. Apr. 3, 2020); *South Wind Women's Center v. Stitt*, No. CIV-20-277-G, 2020 WL 1677094 (W.D. Okla. Apr. 6, 2020).

Id. at 26. The Court rejected this claim. Famously, it explained that the "liberty secured by the Constitution . . . does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint." *Id.* Rather, "a community has the right to protect itself against an epidemic of disease which threatens the safety of its members." *Id.* at 27. In describing a state's police power to combat an epidemic, the Court explained:

> [I]n every well-ordered society charged with the duty of conserving the safety of its members the rights of the individual in respect of his liberty may at times, under the pressure of great dangers, be subjected to such restraint, to be enforced by reasonable regulations, as the safety of the general public may demand.

Id. at 29.

The Supreme Court has repeatedly acknowledged this principle. *See, e.g.*, *Lawton v. Steele*, 152 U.S. 133, 136 (1894) (recognizing that "the state may interfere wherever the public interests demand it" and "discretion is necessarily vested in the legislature to determine, not only what the interests of the public require, but what measures are necessary for the protection of such interests"); *Compagnie Francaise de Navigation a Vapeur v. La. State Bd. of Health*, 186 U.S. 380, 393 (1902) (upholding Louisiana's right to quarantine passengers aboard vessel—even where all were healthy—against a Fourteenth Amendment challenge); *Prince v. Massachusetts*, 321 U.S. 158, 166–67 (1944) (noting that "[t]he right to practice religion freely does not include liberty to expose the community . . . to communicable disease"); *United States v. Caltex*, 344 U.S. 149, 154 (1952) (acknowledging that "in times of imminent peril—such as when fire threatened a whole community—the sovereign could, with immunity, destroy the property of a few that the property of many and the lives of many more could be saved").

To be sure, individual rights secured by the Constitution do not disappear during a public health crisis, but the Court plainly stated that rights

could be reasonably restricted during those times. *Jacobson*, 197 U.S. at 29. Importantly, the Court narrowly described the scope of judicial authority to review rights-claims under these circumstances: review is "only" available

> if a statute purporting to have been enacted to protect the public health, the public morals, or the public safety, has *no real or substantial relation to those objects*, or is, *beyond all question, a plain, palpable invasion of rights secured by the fundamental law*.

Id. at 31 (emphasis added). Elsewhere, the Court similarly described this review as asking whether power had been exercised in an "arbitrary, unreasonable manner," *id.* at 28, or through "arbitrary and oppressive" regulations, *id.* at 38. *Accord Lawton*, 152 U.S. at 137 ("To justify the state in thus interposing its [police power] in behalf of the public, it must appear [1] that the interests of the public generally . . . require such interference; and [2] that the means are reasonably necessary for the accomplishment of the purpose, and not unduly oppressive upon individuals.").

Jacobson did emphasize, however, that even an emergency mandate must include a medical exception for "[e]xtreme cases." 197 U.S. at 38. Thus, the vaccination mandate could not have applied to an adult where vaccination would exacerbate a "particular condition of his health or body." *Id.* at 38–39. In such a case, the judiciary would be "competent to interfere and protect the health and life of the individual concerned." *Id.* at 39. At the same time, *Jacobson* disclaimed any judicial power to second-guess the state's policy choices in crafting emergency public health measures: "Smallpox being prevalent and increasing at Cambridge, the court would *usurp the functions of another branch of government* if it adjudged, as matter of law, that the mode adopted under the sanction of the state, to protect the people at large was arbitrary, and not justified by the necessities of the case." *Jacobson*, 197 U.S. at 28 (emphasis added); *see also id.* at 30 ("It is no part of the function of a court or a jury to determine which one of two modes was likely to be the most

effective for the protection of the public against disease. That was for the legislative department to determine in the light of all the information it had or could obtain.").

The bottom line is this: when faced with a society-threatening epidemic, a state may implement emergency measures that curtail constitutional rights so long as the measures have at least some "real or substantial relation" to the public health crisis and are not "beyond all question, a plain, palpable invasion of rights secured by the fundamental law." *Id.* at 31. Courts may ask whether the state's emergency measures lack basic exceptions for "extreme cases," and whether the measures are pretextual—that is, arbitrary or oppressive. *Id.* at 38. At the same time, however, courts may not second-guess the wisdom or efficacy of the measures. *Id.* at 28, 30.

Jacobson remains good law. *See, e.g.*, *Kansas v. Hendricks*, 521 U.S. 346, 356–57 (1997) (recognizing Fourteenth Amendment liberties may be restrained even in civil contexts, relying on *Jacobson*); *Hickox v. Christie*, 205 F. Supp. 3d 579 (D.N.J. 2016) (rejecting, based on *Jacobson*, a § 1983 lawsuit concerning 80-hour quarantine of nurse returning from treating Ebola patients in Sierra Leone). And, most importantly for the present case, nothing in the Supreme Court's abortion cases suggests that abortion rights are somehow exempt from the *Jacobson* framework. Quite the contrary, the Court has consistently cited *Jacobson* in its abortion decisions.

In *Roe v. Wade*, the Supreme Court announced for the first time that an expectant mother has a constitutional right to an abortion. 410 U.S. 113. Nineteen years later, in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Court reaffirmed this right and established the current standard for abortion restrictions. 505 U.S. 833. *Casey* recognized that after a fetus is viable, states may ban abortion outright, except for pregnancies that endanger the mother's life or health. *Id.* at 846 (plurality opinion). After *Casey*, there remain

two constitutional restrictions on states' ability to regulate abortion. First, states "may not prohibit any woman from making the ultimate decision to terminate" a pre-viability pregnancy. *Gonzales v. Carhart*, 550 U.S. 124, 146 (2007) (quoting *Casey*, 505 U.S. at 879 (plurality opinion)). In other words, states may not impose outright bans on pre-viability abortions. *See Jackson Women's Health Org. v. Dobbs* [*Jackson II*], 945 F.3d 265, 273 (5th Cir. 2019). Second, states "may not impose" on the right "an undue burden, which exists if a regulation's 'purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability.'" *Id.* (quoting *Casey*, 505 U.S. at 878 (plurality opinion)); *see also Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2016) (explaining "[t]he rule announced in *Casey* . . . requires that courts consider the burdens a law imposes of abortion access together with the benefits those laws confer").

None of these cases, so far as we are aware, involved a state's postponement of some abortion procedures in response to a public health crisis—the context in which *Jacobson* plainly applies. But three of the Court's principal abortion cases—*Roe*, *Casey*, and *Carhart*—cite *Jacobson* with approval and without suggesting that abortion rights are somehow exempt from its framework. In *Roe*, the Supreme Court cited *Jacobson* as one example of the Court's refusal to recognize an "unlimited right to do with one's body as one pleases." 410 U.S. at 154 (citing *Jacobson*, 197 U.S. 11). The Court reasoned that the right to abortion "is not unqualified and must be considered against important state interests in regulation." *Id.* Similarly, in *Casey*, the plurality cited *Jacobson* as one example of the Court's balance between "personal autonomy and bodily integrity" on one hand and "governmental power to mandate medical treatment or to bar its rejection" on the other. 505 U.S. at 857 (citing *Jacobson*, 197 U.S. at 24–30). Finally, in the course of upholding a federal restriction on certain abortion methods in *Carhart*, the

Court cited *Jacobson* to show it had "given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty." 550 U.S. at 163 (citing *Jacobson*, 197 U.S. at 30–31).

By all accounts, then, the effect on abortion arising from a state's emergency response to a public health crisis must be analyzed under the standards in *Jacobson*. Respondents all but concede this point, offering no discernible argument that *Jacobson* has been superseded or is otherwise inapplicable during a public health crisis such as the COVID-19 pandemic. *See* ECF 53 at 16. The district court, however, failed to recognize *Jacobson*'s long-established framework. While acknowledging that "Texas faces it[s] worst public health emergency in over a century," the court treated that fact as entirely irrelevant. Indeed, the court explicitly refused to consider how the Supreme Court's abortion cases apply to generally-applicable emergency health measures, saying it would "not speculate on whether the Supreme Court included a silent 'except-in-a-national-emergency clause' in its previous writings on the issue." App. 268.

That analysis is backwards: *Jacobson* instructs that *all* constitutional rights may be reasonably restricted to combat a public health emergency. We could avoid applying *Jacobson* here only if the Supreme Court had specifically exempted abortion rights from its general rule. It has never done so. To the contrary, the Court has repeatedly cited *Jacobson* in abortion cases without once suggesting that abortion is the only right exempt from limitation during a public health emergency. In sum, by refusing even to consider *Jacobson*—the controlling Supreme Court precedent that squarely governs judicial review of rights-challenges to emergency public health measures—the district court "clearly and indisputably erred." *JPMorgan Chase*, 916 F.3d at 500 (quoting *In re Occidental Petroleum Corp.*, 217 F.3d 293, 295 (5th Cir. 2000)) (emphasis omitted). Under our precedents, that alone is enough to satisfy the second

mandamus prong. *See Itron*, 883 F.3d at 568 (petitioners had a "clear and indisputable right to the writ" because failure to apply the proper legal standard was "obvious" error); *see also In re Ford Motor Co.*, 591 F.3d 406, 415 (5th Cir. 2009) (granting writ where "[i]t was patently erroneous for the [district] court to ignore . . . binding precedent").

2.

Moreover, the district court's refusal to acknowledge or apply *Jacobson*'s legal framework produced a "patently erroneous" result. *JPMorgan Chase*, 916 F.3d at 500 (quoting *Lloyd's Register*, 780 F.3d at 290). Under *Jacobson*, the district court was empowered to decide only whether GA-09 lacks a "real or substantial relation" to the public health crisis or whether it is "beyond all question, a plain, palpable invasion" of the right to abortion. 197 U.S. at 31. On the record before us, the answer to both questions is no, but the district court did not even ask them. Instead, the court bluntly declared GA-09 an "outright ban" on pre-viability abortions and exempted all abortion procedures, in whatever circumstances, from the scope of this emergency public health measure. That was a patently erroneous result.[19]

a.

The first *Jacobson* inquiry asks whether GA-09 lacks a "real or substantial relation" to the crisis Texas faces. *Id.* The answer is obvious: the district court itself conceded that GA-09 is a valid emergency response to the COVID-19 pandemic. The court recognized, as does everyone involved, that

[19] Although not necessary to our decision, we note that the district court purported to enjoin GA-09 as to *all* abortion providers in Texas. But Respondents are only a subset of Texas abortion providers and did not sue as class representatives. The district court lacked authority to enjoin enforcement of GA-09 as to anyone other than the named plaintiffs. *See Doran v. Salem Inn, Inc.*, 422 U.S. 922, 931 (1975) (explaining "neither declaratory nor injunctive relief can directly interfere with enforcement of contested statutes or ordinances except with respect to the particular federal plaintiffs"). The district court should be mindful of this limitation on federal jurisdiction at the preliminary injunction stage.

Texas faces a public health crisis of unprecedented magnitude and that GA-09 "does not exceed the governor's power to deal with the emergency." App. 268. Our own review of the record easily confirms that conclusion. GA-09 is supported by findings that (1) "a shortage of hospital capacity or personal protective equipment would hinder efforts to cope with the COVID-19 disaster," and (2) "hospital capacity and personal protective equipment are being depleted by surgeries and procedures that are not medically necessary to correct a serious medical condition or to preserve the life of a patient." App. 34. The order also references, and reinforces, the Governor's prior executive order, GA-08, "aimed at slowing the spread of COVID-19." *Id.*[20] Accordingly, GA-09 instructs licensed health care professionals and facilities to postpone non-essential surgeries and procedures until 11:59 p.m. on April 21, 2020. App. 35. For their part, Respondents appear to concede the validity of GA-09 as a general matter: they recognize that Texas faces an "unprecedented public health crisis" and that "[g]overnment officials and medical professionals expect a surge of infections that will test the limits of a health care system already facing a shortage of PPE." ECF 53 at 3.

To be sure, GA-09 is a drastic measure, but that aligns it with the numerous drastic measures Petitioners and other states have been forced to take in response to the coronavirus pandemic. Faced with exponential growth of COVID-19 cases, states have closed schools, sealed off nursing homes, banned social gatherings, quarantined travelers, prohibited churches from holding public worship services, and locked down entire cities. These measures would be constitutionally intolerable in ordinary times, but are recognized as

[20] Tex. Exec. Order No. GA-08 (Mar. 19, 2020), https://gov.texas.gov/uploads/files/press/EO-GA_08_COVID-19_preparedness_and_mitigation_FINAL _03-19-2020_1.pdf. The dissent is therefore mistaken that GA-09 "was not adopted to serve th[e] interest" in preventing the spread of COVID-19. Dissent at 12.

appropriate and even necessary responses to the present crisis. So, too, GA-09. As the state's infectious disease expert points out, "[g]iven the risk of transmission in health care settings" there is "a sound basis for limiting all surgeries except those that are immediately medically necessary so as to prevent the spread of COVID 19." App. 242. In sum, it cannot be maintained on the record before us that GA-09 bears "no real or substantial relation" to the state's goal of protecting public health in the face of the COVID-19 pandemic. *Jacobson*, 197 U.S. at 31.

b.

The second *Jacobson* inquiry asks whether GA-09 is "*beyond question*, in palpable conflict with the Constitution." *Id.* (emphasis added). The district court, while not framing the question in those terms, evidently thought the answer was yes. But the court reached that conclusion only by grossly misreading GA-09 as an "outright ban" on all pre-viability abortions. Properly understood, GA-09 merely postpones certain non-essential abortions, an emergency measure that does not plainly violate *Casey* in the context of an escalating public health crisis. As we explain below, however, Respondents will have the opportunity to show at the upcoming preliminary injunction hearing that certain applications of GA-09 *may* constitute an undue burden under *Casey*, if they prove that, "beyond question," GA-09's burdens outweigh its benefits in those situations. *See Hellerstedt*, 136 S. Ct. at 2309.

To begin with, the district court's central (and only) premise—that GA-09 is an "outright ban" on all pre-viability abortions—is plainly wrong. The court reasoned that GA-09 was by definition invalid in light of our decisions in *Jackson II* and *Jackson III*, which recognize states cannot ban pre-viability abortions. App. 267–68. But GA-09 only delays certain non-essential abortions. GA-09 thus differs from the regulations in *Jackson II* and *III* in three key respects. First, GA-09 expires on April 21, 2020, three weeks after its effective

date. Tex. Gov't Code Ann. § 418.012. Second, GA-09 includes an emergency exception for the mother's life and health, based on the determination of the administering physician. App. 30; App. 35. Third, GA-09 contains a separate exception for "any procedure" that, if performed under normal clinical standards, "would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster." App. 35. These characteristics, which the district court failed to mention,[21] place GA-09 in stark contrast with the restrictions in *Jackson II* and *III*.

Jackson II invalidated Mississippi's ban on abortions after fifteen weeks, with narrow exceptions for "medical emergenc[ies]" and "severe fetal abnormalit[ies]." 945 F.3d at 269 (citations omitted). The state "conceded that it had identified no medical evidence that a fetus would be viable at 15 weeks." *Id.* at 270. We invalidated the law as "a prohibition on pre-viability abortion." *Id.* at 272–73. Mississippi also enacted Senate Bill 2116, which criminalized abortion "after a 'fetal heartbeat has been detected,'" *Jackson Women's Health Org. v. Dobbs [Jackson III]*, 951 F.3d 246, 248 (5th Cir. 2020) (citation omitted), something that "can occur anywhere between six and twelve weeks." *Id.* The only exceptions were for "death of, or serious risk of 'substantial and irreversible' bodily injury to" the mother. *Id.* (citation omitted). We invalidated the law in a one-page per curiam opinion relying principally on *Jackson II*. *Id.*

Mississippi's now-invalid laws are quite different from GA-09. First, both were permanent, whereas GA-09 expires in just a few weeks.[22] The expiration

[21] The district court's only allusion to the scope of GA-09 was its statement that the order "either bans all *non-emergency* abortions in Texas or bans all *non-emergency* abortions in Texas starting at 10 weeks of pregnancy." App. 267–68 (emphasis added). But the district court did not mention GA-09's expiration date, nor cite, quote, or discuss GA-09's exceptions.

[22] Respondents imply that GA-09 is effectively indefinite in duration. For example, they claim that "[f]or many women, the denial of access to abortion will be permanent . . . given the uncertain duration of the emergency." But the district court did not temporarily restrain some indefinite regulation; it restrained GA-09, which by all accounts expires on

date makes GA-09 a delay, not a ban, and also shows GA-09 is reasonably tailored to the present crisis. "The Supreme Court has repeatedly upheld a wide variety of abortion regulations that entail some delay in the abortion but that serve permissible Government purposes," even those—such as parental consent laws—that "in practice can occasion real-world delays of several weeks." *Garza v. Hargan*, 874 F.3d 735, 755 (D.C. Cir. 2017) (en banc) (mem.) (Kavanaugh, J., dissenting). Second, Mississippi's laws contained narrower medical exceptions than GA-09. The fifteen-week ban exempted only "medical emergenc[ies]" and "severe fetal abnormalit[ies]." *Jackson II*, 945 F.3d at 269. The fetal-heartbeat law exempted only abortions that would prevent the mother's death or "substantial and irreversible" bodily injury. *Jackson III*, 951 F.3d at 248. GA-09, by contrast, contains a broader exception: it allows procedures that are "immediately medically necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death." App. 35. It also separately exempts procedures that, if performed under accepted clinical standards, would not deplete needed medical resources. *Id.*

GA-09 also vests far more discretion in physicians to determine whether the life-or-health exception is met. The fifteen-week ban in *Jackson II* required a "good faith clinical judgment" of a medical emergency, Miss. Code Ann. § 41-41-191(3)(j), and the physician's "reasonable medical judgment" of a qualifying fetal abnormality, *id.* § 41-41-191(3)(h). The fetal-heartbeat law required the physician to "declare in writing, under penalty of perjury," that the abortion

April 21, 2020. App. 35. If anything, Respondents' concern about the indefinite duration "of the emergency" serves to strengthen Petitioners' position that "extraordinary measures" must be taken now to mitigate the "'exponential increase' in COVID-19 cases . . . expected over the next few days and weeks." ECF 2 at 6.

met the exception, *id.* § 41-41-34.1(2)(b)(ii). Here, GA-09 merely states that the health exception attaches "as determined by the patient's physician." App. 35. There are no statutory requirements confining the physician's judgment, and the physician need not report his determination to the state.

Properly understood, then, GA-09 is a temporary postponement of all non-essential medical procedures, including abortion, subject to facially broad exceptions. Because that does not constitute anything like an "outright ban" on pre-viability abortion, GA-09 "cannot be affirmed to be, *beyond question*, in palpable conflict with the Constitution." *Jacobson*, 197 U.S. at 31 (emphasis added). As already discussed, the Supreme Court's abortion cases have repeatedly cited *Jacobson* to demarcate the limits states may place on abortion. *See Roe*, 410 U.S. at 154; *Casey*, 505 U.S. at 857; *Carhart*, 550 U.S. at 163. GA-09 is, without question, one such limit. The order is a concededly valid public health measure that applies to "all surgeries and procedures," App. 35, does not single out abortion, and merely has the effect of delaying certain non-essential abortions. Moreover, the order has an exemption for serious medical conditions, comporting with *Jacobson*'s requirement that health measures "protect the health and life" of susceptible individuals. *Jacobson*, 197 U.S. at 39. Indeed, the exemption in GA-09 goes well beyond the exceptions for "[e]xtreme cases" *Jacobson* discussed. *Id.* In sum, *Jacobson* offers no basis for the district court's conclusion that abortion rights merit an across-the-board exemption from an measure like GA-09. To find otherwise "would practically strip the [executive] department of its function to care for the public health and the public safety when endangered by epidemics of disease." *Id.* at 37.

Moreover, due to its mistaken view that GA-09 "bans" pre-viability abortions, the district court failed to analyze GA-09 under *Casey*'s undue-burden test. App. 268. This was error. Under *Casey*, courts must ask whether an abortion restriction is "undue," which requires "consider[ing] the burdens a

law imposes on abortion access together with the benefits those laws confer." *Hellerstedt*, 136 S. Ct. at 2310, 2309–10 (discussing *Casey*, 505 U.S. at 887–98). The district court was required to do this analysis—that is, it should have asked whether GA-09 imposes burdens on abortion that "beyond question" exceed its benefits in combating the epidemic Texas now faces. *Jacobson*, 197 U.S. at 31. But that analysis would have required careful parsing of the evidence. *See Hellerstedt*, 136 S. Ct. at 2310 (*Casey* "place[s] considerable weight upon evidence . . . presented in judicial proceedings"). Any consideration of the evidence, however, is entirely absent from the district court's order.

For example, the district court did not consider whether different methods of abortion may consume PPE differently. Our own review of the record, at this preliminary stage, reveals considerable evidence that surgical abortions consume PPE.[23] By contrast, the record is unclear how PPE is consumed in medication abortions.[24] Nor did the district court consider

[23] For instance, Respondents' complaint states that clinicians use "gloves, a surgical mask, and protective eyewear" for surgical abortions. *See* Complaint at ¶ 54 (App. 17). Their declarations similarly attest that surgical abortions consume sterile and non-sterile gloves, masks, gowns, and shoe covers. *See* Southwestern Declaration ¶ 19, App. 86; Fort Worth and McAllen Declaration ¶ 10, App. 91–92; PPGTSHS Declaration, ¶ 12, App. 117; Austin Women's Declaration ¶ 11, App. 110. Second-trimester abortions require more extensive PPE, including face shields. *See, e.g.,* Southwestern Declaration ¶ 19, App. 86; Austin Women's Declaration ¶ 11, App. 110. After a surgical abortion, a provider examines the fetal tissue in a pathology laboratory, which requires a gown, face shield or goggles, shoe covers, and gloves. *See* Fort Worth and McAllen Declaration ¶ 12, App. 092; WWHA Austin Declaration ¶ 15, App. 100.

[24] Respondents assert PPE is not used in "providing the pills" for medication abortions, ECF 53 at 31, whereas Petitioners counter that, for medication abortions, Texas requires a physical examination, ultrasound, and follow-up visits—all of which consume PPE. ECF 67 at 7–8; ECF 2 at 17–18. *See also* Tex. Health & Safety Code § 171.063(c) (requiring physician to examine pregnant woman before prescribing "an abortion-inducing drug"); Tex. Health & Safety Code § 171.012(a)(4) (requiring patient receive ultrasound during initial examination); Tex. Health & Safety Code § 171.063(e)–(f) (requiring follow-up appointment to ensure abortion complete); 25 Tex. Admin. Code 139.53(b)(4) (same). Petitioners also point out that some number of medication abortions result in incomplete abortions that require

whether Respondents could prove that GA-09 infringes abortion rights in specific contexts. For example, in their stay opposition, Respondents argue that GA-09 cannot apply to "patients whose pregnancies will, before the expiration of the stay, reach or exceed twenty-two weeks LMP ["last menstrual period"], the gestational point at which abortion may no longer be provided in Texas." ECF 30 at 21 (brackets added). As Petitioners point out, if competent evidence shows that a woman is in that position, nothing prevents her from seeking as-applied relief. ECF 2 at 22 n.28.

We do not decide at this stage, however, whether an injunction narrowly tailored to particular circumstances would pass muster under the *Jacobson* framework. *See*, *e.g.*, *ODonnell v. Harris Cty.*, 892 F.3d 147, 163 (5th Cir. 2018) ("A district court abuses its discretion if it does not narrowly tailor an injunction to remedy the specific action which gives rise to the order." (citation and internal quotations omitted)). These are issues that the parties may pursue at the preliminary injunction stage, where Respondents will bear the burden to prove, "by a clear showing," that they are entitled to relief. *See Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997) (quoting 11A Wright, Miller, & Kane, Fed. Prac. & Proc. § 2948 (2nd ed. 1995)); *cf. Ayotte v. Planned Parenthood*, 546 U.S. 320, 331 (2006) (injunction should be tailored to "[o]nly [the] few applications" of challenged statute that "would present a constitutional problem"). Our overarching point here is that the district court did not even apply *Casey*'s undue-burden test and thus failed to weigh GA-09's

hospitalization. ECF 2 at 18; ECF 67 at 7–8; *see also* American College of Obstetricians and Gynecologists, Clinical Guidelines: Medical management of first-trimester abortion, 89 Contraception 148, 149 (2014), https://www.contraceptionjournal.org/article/S0010-7824(14)00026-2/pdf (estimating "efficacy" of medication abortions using mifepristone). The dissent appears to accept at face value Respondents' representations about how medication abortions consume PPE. *See* Dissent at 11. We think that evidentiary determination is better left to the district court at the preliminary injunction stage.

benefits and burdens in any particular circumstance. The district court therefore lacked any basis for declaring that GA-09 constitutes an across-the-board violation of *Casey*.

In sum, based on this record we conclude that GA-09—an emergency measure that postpones certain non-essential abortions during an epidemic—does not "beyond question" violate the constitutional right to abortion. *Jacobson*, 197 U.S. at 31.

3.

Finally, the district court's extraordinary failure to evaluate GA-09 under the *Jacobson* framework also usurped the state's authority to craft measures responsive to a public health emergency. Such judicial encroachment intrudes on the duties of the "executive arm of Government" and "on a delicate area of federal-state relations," further bolstering Texas's right to issuance of the writ. *Cheney*, 542 U.S. at 381.

In addressing the fourth and final TRO factor—whether a TRO would disserve the public interest—the district court did little more than assert its own view of the effectiveness of GA-09. The district court did not provide any explanation of its conclusion that the public health benefits from an emergency measure like GA-09 are "outweighed" by any temporary loss of constitutional rights. Instead, the court rotely concluded that all injunctions vindicating constitutional rights serve the public interest and that a TRO would "continue the *status quo*." App. 270. With respect, that blinks reality. The *status quo* Texas faces, along with the rest of the nation, is a public health crisis that is making once-in-a-lifetime demands on citizens, government, industry, and the medical profession. Where there is a *status quo* to preserve, it is certainly true that an injunction does "not disserve the public interest [if] it will prevent constitutional deprivations." *Jackson Women's Health Org. v. Currier [Jackson I]*, 760 F.3d 448, 458 n.9 (5th Cir. 2014). But the essence of equity is the ability

to craft a particular injunction meeting the exigencies of a particular situation. "Flexibility rather than rigidity has distinguished it." *Hecht Co. v. Bowles*, 321 U.S. 321, 329 (1944). Thus, a court must at the very least weigh the potential injury to the public health when it considers enjoining state officers from enforcing emergency public health laws. A single conclusory statement that does not explain this balancing falls far short.

Instead of doing any of this, the district court substituted its *ipse dixit* for the Governor's reasoned judgment, bluntly concluding that "[t]he benefits of a limited potential reduction in the use of some personal protective equipment by abortion providers is outweighed by the harm of eliminating abortion access in the midst of a pandemic that increases the risks of continuing an unwanted pregnancy." App. 270. Respondents—as well as our dissenting colleague—share this view. ECF 53 at 2, 17–21; Dissent at 11–12.

As *Jacobson* repeatedly instructs, however, if the choice is between two reasonable responses to a public crisis, the judgment must be left to the governing state authorities. "It is no part of the function of a court or a jury to determine which one of two modes [i]s likely to be the most effective for the protection of the public against disease." *Jacobson*, 197 U.S. at 30. Such authority properly belongs to the legislative and executive branches of the governing authority. In light of the massive and rapidly-escalating threat posed by the COVID-19 pandemic, "the court would *usurp the functions of another branch of government* if it adjudged, as matter of law, that the mode adopted under the sanction of the state, to protect the people at large was arbitrary, and not justified by the necessities of the case." *Id.* at 28 (emphasis added). The district court's order contravened this principle; Respondents and the dissenting opinion invite us to do the same. We decline to engage in such "unwarranted judicial action." *Will*, 389 U.S. at 95.

To be sure, the judiciary is not completely sidelined in a public health crisis. We have already explained that Respondents may seek more targeted relief, if they can prove their entitlement to it, at the preliminary injunction stage. Additionally, a court may inquire whether Texas has exploited the present crisis as a pretext to target abortion providers *sub silentio*. *See Lawton*, 152 U.S. at 137. Respondents make allegations to that effect, contending that Petitioners are using GA-09 "to exploit the COVID-19 pandemic to achieve their longtime goal of banning abortion in Texas." ECF 53 at 1. Nonetheless, on this record, we see no evidence that GA-09 was meant to exploit the pandemic in order to ban abortion or was crafted "as some kind of ruse to unreasonably delay . . . abortion[s] past the point where a safe abortion could occur." *Garza*, 874 F.3d at 753 n.3 (Kavanaugh, J., dissenting). To the contrary, GA-09 applies to a whole host of medical procedures and regulates abortions evenhandedly with those other procedures. The order itself does not even mention abortion—or any other particular procedure—at all. Instead, it refers broadly to "all surgeries or procedures" that meet its criteria.[25] Respondents point to no evidence that GA-09 applies any differently to abortions than to any other procedure. Nor do they cite any comparable procedures that are exempt from GA-09's requirements. On the other hand, Petitioners produce evidence that myriad other procedures are affected just as abortions are. For example, Petitioners offer a declaration from Dr. Timothy Harstad, M.D., who testified that some cosmetic, bariatric, orthopedic, and gynecologic procedures

[25] The district court relied heavily on the Attorney General's press release of March 23, 2020, which clarified that in the Attorney General's view, the GA-09 "includ[es] abortion providers." App. 31, 264–65. But the district court gave no reason to believe this press release has the force of law. And, in any event, the press release also reads the order to apply "to all surgeries and procedures[,] . . . including routine dermatological, ophthalmological, and dental procedures, as well as . . . orthopedic surgeries or any type of abortion that is not medically necessary to preserve the life or health of the mother." App. 30.

"are being suspended" alongside abortions. App. 230–31. Petitioners also point to the fact that the Centers for Medicare & Medicaid Services have recommended postponing several other critical procedures, including endoscopies and colonoscopies, and even some oncological and cardiovascular procedures for low-risk patients.[26] This evidence undermines Respondents' contention that GA-09 exploits the present crisis to ban abortion. Respondents will have the opportunity, of course, to present additional evidence in conjunction with the district court's preliminary injunction hearing scheduled for April 13, 2020. Our decision, however, must be limited to the record before us. Based on that record, we cannot say that GA-09 is a pretext for targeting abortion.

The district court, for its part, did not even purport to engage in the sort of limited pretext inquiry contemplated by cases like *Jacobson* and *Lawton*. Instead, the district court overstepped its proper role and imposed its own judgment about how the COVID-19 pandemic should be handled with respect to abortion.[27] This was a usurpation of the state's power. *Will*, 389 U.S. at 95.

[26] *See* CMS Adult Elective Surgery and Procedures Recommendations, https://www.cms.gov/files/document/31820-cms-adult-elective-surgery-and-procedures-recommendations.pdf (last visited April 6, 2020).

[27] Likewise, the dissent contends that "[r]estricting contact between abortion providers and their patients cannot further the goals of GA-09 if the same order permits in-person contact between providers and patients in other settings." Dissent at 13. But this is true of all surgeries and procedures. Nonetheless, in part to "limit[ ] exposure of patients and staff to the virus that causes COVID-19," CMS recommends postponing "non-essential surgeries and other procedures." *See* CMS Adult Elective Surgery and Procedures Reccomendations (Mar. 15, 2020), https://www.cms.gov/files/document/31820-cms-adult-elective-surgery-and-procedures-recommendations.pdf. GA-09 notes that it follows recommendations from "the President's Coronavirus Task Force, the CDC, the U.S. Surgeon General, and the Centers for Medicare and Medicaid Services." And the state's infectious disease expert said that the risk of spreading the virus is real, "especially in the health care setting due to the proximity." Marier Declaration ¶ 6, App. 240. We reiterate that *Jacobson* commands that it is not the court's role "to determine which one of two modes [i]s likely to be most effective for the protection of the public against disease." 197 U.S. at 30.

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In sum, based on the record before us, we conclude that Petitioners have a clear and indisputable right to issuance of the writ, satisfying the second mandamus prong. *Itron*, 883 F.3d at 567.

B.

We now consider whether Petitioners have shown they "have no other adequate means" to obtain the relief they seek. *Cheney*, 542 U.S. at 380. This requirement is "designed to ensure that the writ will not be used as a substitute for the regular appeals process." *Id.* at 380–81. Mandamus is generally unavailable for review of "district court decisions that, while not immediately appealable, can be reviewed at some juncture." *In re Crystal Power Co.*, 641 F.3d 82, 83 (5th Cir. 2011). "[F]or an appeal to be an inadequate remedy, there must be 'some obstacle to relief beyond litigation costs that renders obtaining relief not just expensive but effectively unobtainable.'" *Depuy Orthopaedics*, 870 F.3d at 353 (quoting *Lloyd's Register*, 780 F.3d at 289). In other words, the error claimed must be "truly irremediable on ordinary appeal." *JPMorgan Chase*, 916 F.3d at 499 (cleaned up) (quoting *Depuy*, 870 F.3d at 352–53).

Given the surging tide of COVID-19 cases and deaths, Petitioners have made this showing. In mill-run cases, it might be a sufficient remedy to simply wait until the expiration of the TRO, and then appeal an adverse preliminary injunction. *See* 28 U.S.C. § 1292(a)(1). In other cases, a surety bond may ensure that a party wrongfully enjoined can be compensated for any injury caused. *See* Fed. R. Civ. P. 65(c).

Those methods would be woefully inadequate here. The TRO is set to expire April 13, 2020, two weeks from the date it issued. App. 271. But time is of the essence when it comes to preventing the spread of COVID-19 and conserving medical resources critically needed to care for patients. To illustrate the speed at which the pandemic has been unfolding: As of March 20 there

were, per the WHO's daily report, 234,073 confirmed cases of COVID-19 and 9,840 deaths.[28] As of April 6, there were 1,210,956 confirmed cases, and 67,954 deaths.[29] As of April 1, Texas had 4,544 cases; by April 6, the number had risen to 7,359 cases.[30] That number will undoubtedly rise substantially in coming days absent successful preventative measures. As the Dallas Morning News wrote on April 1: "The greatest number of cases will come in about a 10-day period that will begin soon."[31] On April 2, Respondents conceded that "[g]overnment officials and medical professionals expect a surge of infections that will test the limits of a health care system already facing a shortage of PPE[.]" ECF 53 at 3. Respondents also concede that surgical abortions consume PPE, such as "gloves, a surgical mask, disposable protective eyewear, disposable or washable gowns, and . . . shoe covers." *Id.* at 6. Moreover, abortion is a common procedure: the evidence shows 53,843 total abortions—36,793 of those surgical—were performed in Texas in 2017. App. 222. In sum, were Petitioners required to wait and appeal an adverse preliminary injunction, the harms from a broad suspension of GA-09 for all abortion procedures could not "be put back in the bottle." *Volkswagen*, 545 F.3d at 319.

[28] WORLD HEALTH ORGANIZATION, CORONAVIRUS DISEASE 2019 (COVID-19) SITUATION REPORT – 60 (March 20, 2020), https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200320-sitrep-60-covid-19.pdf?sfvrsn=d2bb4f1f_2.

[29] WORLD HEALTH ORGANIZATION, CORONAVIRUS DISEASE 2019 (COVID-19) SITUATION REPORT – 77 (April 6, 2020), https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200406-sitrep-77-covid-19.pdf?sfvrsn=21d1e632_2.

[30] Johns Hopkins University & Medicine Coronavirus Resource Center, Coronavirus COVID-10 Global Cases, https://coronavirus.jhu.edu/map.html (last visited April 6, 2020).

[31] Steven Gjerstad, *U.S. cases of COVID-19 will peak in a couple of weeks; Only social distancing will break the virus*, DALLAS MORNING NEWS (April 1, 2020), https://www.dallasnews.com/opinion/commentary/2020/04/01/us-cases-of-covid-19-will-peak-in-a-couple-of-weeks-only-social-distancing-will-break-the-virus/

The error would be "truly irremediable" through ordinary appeal. *JPMorgan Chase*, 916 F.3d at 499 (cleaned up).[32]

We therefore conclude no other adequate means exist for Petitioners to obtain the relief they seek, thus satisfying the first mandamus prong.

C.

Finally, we must decide whether to exercise our discretion to issue the writ. *See Gee*, 941 F.3d at 170. "Discretion is involved in defining both the circumstances that justify exercise of writ power and also the reasons that may justify denial of a writ even though the circumstances might justify a grant." 16 WRIGHT & MILLER, *supra*, § 3933. "The longstanding view is that discretion to issue the writs should be exercised only in special cases . . . ." *Id*.

We are persuaded that this petition presents an extraordinary case justifying issuance of the writ. First, as we have noted, the current global pandemic has caused a serious, widespread, rapidly-escalating public health crisis in Texas. Petitioners' interest in protecting public health during such a time is at its zenith. In the unprecedented circumstances now facing our society, even a minor delay in fully implementing the state's emergency measures could have major ramifications because, as the evidence shows, an

[32] Federal courts of appeals have issued writs of mandamus to vacate TROs in a number of less-urgent scenarios. *See, e.g.*, *In re King World Prods., Inc.*, 898 F.2d 56 (6th Cir. 1990) (vacating TRO enjoining news organization from broadcasting video recording); *Truck Drivers Local Union No. 807, Int'l Bhd. of Teamsters v. Bohack Corp.*, 541 F.2d 312 (2d Cir. 1976) (vacating TRO enjoining Board from conducting unfair labor practice proceedings); *O'Neill v. Battisti*, 472 F.2d 789 (6th Cir. 1972) (vacating TRO enjoining Ohio Supreme Court from enforcing its own disciplinary order or taking further disciplinary action against state judge). *A fortiori*, mandamus is an appropriate mechanism for challenging the TRO in the present case, which restrains Petitioners from fully implementing emergency public health measures in a time of unprecedented crisis.

"exponential increase in COVID-19 cases is expected over the next few days and weeks." App. 224–25. It is hard to imagine a more urgent situation.

Second, the district court's refusal to acknowledge the governing framework from *Jacobson* was a clear abuse of discretion that produced a patently erroneous result: bestowing on abortion providers a blanket exemption from a generally-applicable emergency public health measure. Not stopping there, the district court usurped the power of state authorities by passing judgment on the wisdom and efficacy of those emergency measures. These are "extraordinary" errors. *See Volkswagen*, 545 F.3d at 318.

Third, "writs of mandamus are supervisory in nature and are particularly appropriate when the issues also have an importance beyond the immediate case." *Id.* at 319. While unclear how long the current crisis will last, it is probable that other legal disputes will arise pitting claims of private rights against the states' authority to preserve public health and safety. Indeed, 34 states plus the District of Columbia have filed amicus briefs in this case, demonstrating the widespread importance of the issues involved. We also view the "sheer magnitude" of the district court's error and its effect on the state's ongoing emergency efforts to slow COVID-19 as evidence that the "safety valve" of mandamus is appropriate. *Itron*, 883 F.3d at 568–69 (cleaned up).

Lastly, we note that this case is distinguishable from our recent decisions in *Gee* and *JPMorgan Chase*, where, in our discretion, we declined to issue writs of mandamus. In *Gee*, we concluded that, even though the district court clearly abused its discretion in failing to undertake the required jurisdictional analysis, mandamus was nevertheless not required because (1) it was unclear what result the district court would reach once it performed the correct analysis, and (2) many of the petitioner's arguments went beyond jurisdiction and challenged the plaintiffs' theory on the merits. *See* 941 F.3d at 170. In light of those considerations, we deemed it imprudent to issue the writ. *Id.* In

JPMorgan Chase, we concluded that the district court's error, while significant, was not "clear and indisputable" because it "followed numerous others" who had made the same mistake. 916 F.3d at 504.

We confront vastly different circumstances here. To begin with, unlike in *Gee*, the district court addressed the merits of Respondents' claim, though it did so in a manner that overlooked the controlling framework and produced patently erroneous results. *See Volkswagen*, 545 F.3d at 319. Given the severe time constraints here, we do not have the luxury to wait and see what approach the district court might take on the merits. Second, unlike in *JPMorgan Chase*, the district court's decision here did not align with "numerous" other courts which had confronted the same issue. To the contrary, the district court cited not a single case addressing restrictions on abortion during a public health crisis. Therefore, "we are aware of nothing that would render the exercise of our discretion to issue the writ inappropriate." *Volkswagen*, 545 F.3d at 319.

For those reasons, we exercise our discretion to issue a writ of mandamus. *See Cheney*, 542 U.S. at 381.

IV.

The petition for writ of mandamus is GRANTED, directing the district court to vacate the TRO entered on March 30, 2020. Petitioners' emergency motion to stay the TRO pending resolution of their mandamus petition is DENIED AS MOOT. Our temporary stay of March 31, 2020, is LIFTED. Any future appeals or mandamus petitions in this case will be directed to this panel and will be expedited. *Gee*, 941 F.3d at 173; *In re First South Sav. Ass'n*, 820 F.2d 700, 716 (5th Cir. 1987). The mandate shall issue forthwith.

JAMES L. DENNIS, dissenting.

Eight days ago, the district court temporarily restrained Texas's temporary ban of all medication abortions and procedural abortions. "The benefits of a limited potential reduction in the use of some personal protective equipment by abortion providers," the district court explained, "is outweighed by the harm of eliminating abortion access in the midst of a pandemic that increases the risks of continuing an unwanted pregnancy, as well as the risks of travelling to other states in search of time-sensitive medical care." Other states, including Oklahoma,[1] Alabama,[2] and Ohio,[3] have attempted to limit a woman's access to abortion during the COVID-19 pandemic. Thus far, none of those attempts has been successful in the face of a constitutional challenge, either in the district courts or on appeal. *South Wind Women's Center LLC v. Stitt*, No. CIV-20-277-G, 2020 WL 1677094, at *2 (W.D. Okla. Apr. 6, 2020) ("[W]hile the current public health emergency allows the state of Oklahoma to impose some of the cited measures *delaying* abortion procedures, it has acted in an 'unreasonable,' 'arbitrary' and 'oppressive' way—and imposed an 'undue

[1] Okla. Exec. Order No. 2020-07 (Mar. 24, 2020), https://www.sos.ok.gov/documents/executive/1919.pdf; Press Release, Office of the Oklahoma Governor, Governor Stitt Clarifies Elective Surgeries and Procedures Suspended under Executive Order (Mar. 27, 2020), https://www.governor.ok.gov/articles/press_releases/governor-stitt-clarifies-elective-surgeries ("[A]ny type of abortion services . . . which are not a medical emergency . . . or otherwise necessary to prevent serious health risks to the unborn child's mother are included in that Executive Order.")

[2] Order of the State Health Officer Suspending Certain Public Gatherings Due to Risk of Infection by COVID-19 (Mar. 27, 2020), https://governor.alabama.gov/assets/2020/03/Amended-Statewide-Social-Distancing-SHO-Order-3.27.2020-FINAL.pdf; *Robinson v. Marshall*, No. 2:19CV365-MHT, 2020 WL 1520243, at *1 (M.D. Ala. Mar. 30, 2020) (explaining that the Alabama state's attorney "in his oral representations on the record, took the position that the March 27 order requires the postponement of *any* abortion that is not medically necessary to protect the life or health of the mother").

[3] Ohio Department of Health, RE: Director's Order for the Management of Non-essential Surgeries and Procedures throughout Ohio (Mar. 17, 2020); *Preterm-Cleveland v. Attorney Gen. of Ohio*, No. 1:19-cv-00360, slip op. at 2-3 (S.D. Ohio Mar. 30, 2020) (stating that Ohio's attorney general sent letters to abortion providers citing the Director's Order and they must "immediately stop performing non-essential and elective surgical abortions").

burden' on abortion access—in imposing requirements that effectively *deny* a right of access to abortion. Further, the court concludes that the benefit to public health of the ban on medication abortions is minor and outweighed by the intrusion on Fourteenth Amendment rights caused by that ban."); *Robinson v. Marshall*, No. 2:19CV365-MHT, 2020 WL 1520243, at *2 (M.D. Ala. Mar. 30, 2020) ("Because Alabama law imposes time limits on when women can obtain abortions, the March 27 order is likely to fully prevent some women from exercising their right to obtain an abortion. And for those women who, despite the mandatory postponement, are able to vindicate their right, the required delay may pose an undue burden that is not justified by the State's purported rationales."); *Preterm-Cleveland v. Attorney Gen. of Ohio*, No. 1:19-cv-00360, slip op. at 7 (S.D. Ohio Mar. 30, 2020) ("Defendants have not demonstrated to the Court, at this point, that Plaintiffs' performance of these surgical procedures will result in any beneficial amount of net saving of PPE in Ohio such that the net saving of PPE outweighs the harm of eliminating abortion."), *appeal dismissed*, No. 20-3365 (6th Cir. Apr. 6, 2020). The American College of Obstetricians and Gynecologists released a statement that "abortion should not be categorized" as a "procedure[] that can be delayed during the COVID-19 pandemic."[4] The statement emphasized, as the district court did, that abortion is "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks or potentially make it completely inaccessible."

Today, the majority concludes that allowing women in Texas access to time-sensitive reproductive healthcare, a right supported by almost 50 years of Supreme Court precedent, was a "patently erroneous" result that must be

[4] *Joint Statement on Abortion Access During the COVID-19 Outbreak*, THE AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGISTS (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak.

remedied by "one of the most potent weapons in the judicial arsenal." *See In re JPMorgan Chase & Co.*, 916 F.3d 494, 504 (5th Cir. 2019) (quoting *Cheney v. U.S. Dist. Court for D.C.*, 542 U.S. 367, 380 (2004). Unfortunately, this is a recurring phenomenon in this Circuit in which a result follows not because of the law or facts, but because of the subject matter of this case. *See June Med. Servs. L.L.C. v. Gee*, 905 F.3d 787, 835 (5th Cir. 2018) ("[W]hen abortion shows up, application of the rules of law grows opaque." (Higginbotham, J., dissenting)), *cert. granted*, 140 S. Ct. 35 (2019)). For the reasons that follow, I dissent.

I.

On March 22, 2020, Texas Governor Greg Abbott signed Executive Order GA-09 ("GA-09") to expand hospital bed capacity as the state responds to the COVID-19 virus. The Executive Order, which "ha[s] the force and effect of law," TEX. GOV'T CODE ANN. § 418.012 (West 2019), states that until 11:59 p.m. on April 21, 2020,

> [a]ll licensed health care professionals and all licensed health care facilities shall postpone all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician.[5]

The Executive Order exempts "any procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster."

[5] Tex. Exec. Order No. GA-09 (Mar. 22, 2020), https://gov.texas.gov/uploads/files/press/EO-GA_09_COVID-19_hospital_capacity_IMAGE_03-22-2020.pdf.

The day after the Governor signed GA-09, Texas Attorney General Ken Paxton issued a news release stating that GA-09's prohibition on medically unnecessary surgeries and procedures "applies throughout the State and to all surgeries and procedures that are not immediately medically necessary, including . . . any type of abortion that is not medically necessary to preserve the life or health of the mother."[6] The release states that "[f]ailure to comply with an executive order issued by the governor related to the COVID-19 disaster can result in penalties of up to $1,000 or 180 days of jail time." Paxton emphasized that "[n]o one is exempt from the governor's executive order on medically unnecessary surgeries and procedures, including abortion providers," and "[t]hose who violate the governor's order will be met with the full force of the law."

Several organizations that provide abortion services in Texas and a board-certified family medicine physician who provides abortion care (collectively, "Respondents") brought an action in the Western District of Texas under 42 U.S.C. § 1983, challenging GA-09 and the Texas Medical Board's emergency amendment to Title 22 Texas Administrative Code section 187.57, which imposes the same requirements. Respondents moved for a temporary restraining order ("TRO") to enjoin enforcement of GA-09 and the Emergency Rule insofar as they purport to ban all medication abortions and procedural abortions, as the attorney general's news release suggests.

I include this explanation not to reiterate the procedural history the majority has already explained, but to emphasize what exactly we are reviewing. Respondents brought a constitutional challenge to GA-09, and

[6] News Release, Office of the Texas Attorney General, Health Care Professionals and Facilities, Including Abortion Providers, Must Immediately Stop All Medically Unnecessary Surgeries and Procedures to Preserve Resources to Fight COVID-19 Pandemic (Mar. 23, 2020), https://www.texasattorneygeneral.gov/news/releases/health-care-professionals-and-facilities-including-abortion-providers-must-immediately-stop-all.

though the attorney general's interpretation of that order constitutes the crux of the constitutional issues present in this case, it is GA-09 and only GA-09 that we are interpreting. The majority agrees that the attorney general's news release interpreting GA-09 is not legally binding. Maj. Op. at 25 n.22. The attorney general cannot modify the text of the governor's executive order through his news release; only the governor has the power to "issue executive orders . . . [that] have the force and effect of law." TEX. GOV'T CODE ANN. § 418.012. And GA-09 grants abortion providers the power to determine whether a procedure is "immediately medically necessary to correct a serious medical condition of . . . a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences." It also permits an exception for any abortion that "if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster."

The attorney general's news release interprets GA-09 to ban "any type of abortion that is not medically necessary to preserve the life or health of the mother," regardless, apparently, of whether such a procedure (1) in the view of the patient's physician, is immediately medically necessary and would put a patient at risk for serious adverse medical consequences if not performed, or (2) would fall under GA-09's exception for procedures that do not utilize PPE or deplete hospital capacity.

II.

The district court granted Respondents' TRO, halting enforcement of GA-09 insofar as it bans all procedural and medication abortions. Petitioners seek a writ of mandamus to remedy what they describe as a "clearly and indisputably erroneous" decision. The Supreme Court and this court have repeatedly emphasized that mandamus is an "extraordinary remedy" to be

exercised only in "exceptional circumstances." *See Cheney*, 542 U.S. at 380 (quoting *Will v. United States*, 389 U.S. 90, 95 (1967)); *In re Lloyd's Register N. Am., Inc.*, 780 F.3d 283, 288, 294 (5th Cir. 2015); *In re Volkswagen of Am., Inc.*, 545 F.3d 304, 309, 311 (5th Cir. 2008). To obtain relief, Petitioners "must do more than prove merely that the court erred." *In re Occidental Petroleum Corp.*, 217 F.3d 293, 295 (5th Cir. 2000). "The traditional use of the writ . . . has been to confine the court against which mandamus is sought to a lawful exercise of its prescribed jurisdiction." *Cheney*, 542 U.S. at 380 (alteration omitted) (quoting *Roche v. Evaporated Milk Ass'n*, 319 U.S. 21, 26 (1943)). Its use is justified in "only exceptional circumstances amounting to a judicial 'usurpation of power,' or a 'clear abuse of discretion.'" *Id.* (quoting *Will*, 389 U.S. at 95; *Bankers Life & Casualty Co. v. Holland*, 346 U.S. 379, 383 (1953)).

Mandamus relief generally requires that (1) "the party seeking issuance of the writ [must] have no other adequate means to attain the relief he desires—a condition designed to ensure that the writ will not be used as a substitute for the regular appeals process"; (2) "the petitioner must satisfy the burden of showing that [his] right to issuance of the writ is clear and indisputable"; and (3) "the issuing court, in the exercise of its discretion, must be satisfied that the writ is appropriate under the circumstances." *Id.* at 380-81 (internal quotation marks and citations omitted).

Under the "clear and indisputable" prong, *id.*, Petitioners must show the district court's determination was a "clear abuse[] of discretion that produce[d] patently erroneous results." *In re Lloyd's Register N. Am., Inc.*, 780 F.3d at 290 (quoting *In re Volkswagen of Am., Inc.*, 545 F.3d at 312). Both conditions—clear abuse of discretion and a patently erroneous result—must be met to obtain mandamus relief. *See id.*

The majority concludes that the district court clearly erred by not applying *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11 (1905), and

its result, allowing medication and procedural abortions to proceed, was patently erroneous. It also concludes that "the court usurped the power of the governing state authority when it passed judgment on the wisdom and efficacy of those emergency measures, something squarely foreclosed by *Jacobson*." Maj. Op. at 9-10. For several reasons, the majority is wrong.

III.

In *Jacobson*, the city of Cambridge, Massachusetts, pursuant to state statute, passed a regulation requiring all of its citizens to receive a smallpox vaccination to combat a smallpox outbreak. 197 U.S. at 12. Jacobson challenged the regulation, arguing that it violated his Fourteenth Amendment right "to care for his own body and health in such a way as to him seems best." *Id.* at 26. The Court explained that the state's action in compelling vaccination was an exercise of its police power, which "must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety." *Id.* at 25. In rejecting Jacobson's constitutional challenge, the Court explained "[e]ven liberty itself, the greatest of all rights, is not unrestricted license to act according to one's own will. It is only freedom from restraint under conditions essential to the equal enjoyment of the same right by others." *Id.* at 26-27. The Court explained, however, that individual rights are not gutted during a crisis: Courts have a duty to review a state's exercise of their police power where the state's action (1) goes "beyond the necessity of the case, and, under the guise of exerting a police power . . . violate[s] rights secured by the Constitution," (2) "has no real or substantial relation to" "protect[ing] the public health, the public morals, or the public safety," or (3) "is, beyond all question, a plain, palpable invasion of rights secured by the fundamental law." *Id.* at 28, 30. *Jacobson*, then, stands for the proposition that a state by its legislature may utilize its police power to enact laws to protect the public health and safety,

even though such laws may impose restraints on citizens' liberties, so long as that regulation is "justified by the necessities of the case" and does not violate rights secured by the Constitution "under the guise of exerting a police power." *Id.* at 28-29.

A.

This case is clearly distinguishable from *Jacobson*. There, the city required its citizens to get a smallpox vaccine to stop the spread of a smallpox outbreak. The measure adopted by the city related directly to the public health crisis—every citizen who did not receive the vaccine could actively spread the disease, and therefore mandatory vaccination actively curbed the disease's spread. The thread connecting GA-09 to combatting COVID-19 is more attenuated—premised not on the idea that abortion providers are spreading the virus, but that their continuing operation requires the use of resources that should be conserved and made available to healthcare workers fighting the outbreak. This reasoning requires the additional link that those PPE resources denied to abortion providers are indeed conserved, are significant in amount, and can realistically be reallocated to healthcare workers fighting COVID-19, a showing that Petitioners have not made.

B.

The majority claims that "*Jacobson* disclaimed any judicial power to second-guess the policy choices made by the state in crafting emergency public health measures." Maj. Op. at 12. But the Court did not conclude that an emergency situation deprives courts of their duty and power to uphold the constitution—quite the opposite, in fact.

The Court in *Jacobson* determined that the Massachusetts law should not be invalidated because "[s]mallpox being prevalent and increasing in Cambridge, the court would *usurp the functions of another branch of government* if it adjudged, as a matter of law, that the mode adopted under the

sanction of the state, to protect the people at large was arbitrary, and not justified *by the necessities of the case*." *Jacobson*, 197 U.S. at 28 (emphases added). The Court certainly did not disclaim any power to so rule, under appropriate circumstances, however, explaining:

> We say necessities of the case, because it might be that an acknowledged power of a local community to protect itself against an epidemic threatening the safety of all might be exercised in particular circumstances and in reference to particular persons in such an arbitrary, unreasonable manner, or might go so far beyond what was reasonably required for the safety of the public, as to authorize or compel the courts to interfere for the protection of such persons.

Id. The Court in *Jacobson* also explained that it had previously "recognized the right of a state to pass sanitary laws, laws for the protection of life, liberty, [and] health . . . within its limits." *Id.* (citing *Hannibal & St. J.R. Co. v. Husen*, 95 U. S. 465, 471-73 (1877)). While states have the right to pass such laws, the Court explained, the courts have a "duty to hold . . . invalid" laws that "went beyond the necessity of the case, and, under the guise of exerting a police power, invaded the domain of Federal authority, and violated rights secured by the Constitution." *Id.*

Thus, the Court clearly anticipated that courts would exercise judicial oversight over a state's decision to restrict personal liberties during emergencies. *See id.* *Jacobson* merely acknowledged that what is reasonable during an emergency is different from what is reasonable under normal circumstances, and that courts must not act as super-executives in an emergency. Given the language of *Jacobson*, then, the Court was concerned with both what the majority focuses on—the state's ability to adequately protect its citizens during a public health crisis—and what the majority ignores—the courts' ability to protect citizens' constitutional rights when

states attempt to unjustifiably seize and wield power in the name of the health and safety.

Therefore, *Jacobson* reaffirms the district court's duty, and our duty, "to hold [GA-09] invalid" if it (1) goes "beyond the necessity of the case, and, under the guise of exerting a police power . . . violate[s] rights secured by the Constitution," (2) "has no real or substantial relation to" "protect[ing] the public health, the public morals, or the public safety," or (3) "is, beyond all question, a plain, palpable invasion of rights secured by the fundamental law." *See id.* at 28, 30.

IV.

After concluding that the district court clearly abused its discretion in not relying on *Jacobson*, the majority determines that this error produced a patently erroneous result. Maj. Op. at 15-23. The majority claims that the district court's conclusion that GA-09 amounts to a previability ban is patently erroneous. Maj. Op. at 17. In my view, this "conclusion" does not accurately characterize the "result" of the district court's order. *See In re Volkswagen of Am., Inc.*, 545 F.3d at 310 ("[W]e only will grant mandamus relief when such errors produce a patently erroneous *result*." (emphasis added)). The result of the district court's order is to uphold women's rights to abortions and to allow medical and procedural abortions to proceed. That result is not patently erroneous and therefore does not warrant mandamus relief. Contrary to the majority's view, nothing in *Jacobson* or any of the Supreme Court's cases requires a different result.

A.

The goals of GA-09 are furthered by restricting abortions, according to Petitioners, because abortions: (1) "reduce[] the scarce supply of PPE available to healthcare providers treating COVID-19 patients," (2) "result[] in the

hospitalization of women," reducing hospital capacity for COVID-19 patients, and (3) "contribute[] to the spread of the COVID-19 virus."

Though GA-09 does not define PPE, Respondents explain that the term is generally understood to refer to N95 respirators, surgical masks, non-sterile and sterile gloves, and disposable protective eyewear, gowns, and hair and shoe covers. In response to Petitioners' argument that abortions will deplete PPE necessary for healthcare providers treating COVID-19 patients, Respondents contend that abortions utilize little or no PPE and that abortions are time-sensitive procedures.

Regarding the first point, whether an abortion takes no PPE or some PPE depends on the type of procedure. Procedural abortions in Texas are single-day procedures that, unlike surgeries, require no hospital bed, incision, general anesthesia, or sterile field. During the procedure, the providers use PPE such as gloves, a surgical mask, disposable protective eyewear, disposable or washable gowns, and hair and shoe covers. Most Respondents do not have N95 respirators, and those that do have only a small supply that they rarely, if ever, use. Medication abortions, which involve only taking medications by mouth, require no PPE to administer the medication, and may require the use of gloves only at pre- and post-procedure appointments, depending on the circumstances. Petitioners identify no other treatment through oral medication that would be affected by GA-09.

Moreover, Respondents point out that Petitioners' PPE conservation argument mistakenly assumes that a patient unable to obtain an abortion will not otherwise need medical care that requires the consumption of PPE. Pregnant patients who cannot access abortion require prenatal care and must often undergo unplanned hospital visits. And to the extent patients are prevented from obtaining abortions altogether, childbirth and delivery require exponentially more PPE than an abortion. Denying pregnant patients access

to abortion now may simply change the purpose for which the PPE is used, without any surplus that is able to be reallocated to healthcare workers treating COVID-19 patients. Other pregnant patients with the resources to do so may choose to seek abortions outside of Texas—a result clearly contrary to Texas's purported goal of avoiding the spread of the virus. GA-09 has already led patients to travel to other states to obtain abortion care in a pandemic, exposing patients and third parties to infection risks. One out-of-state physician stated that he treated 30 abortion patients from Texas in the week after the attorney general's statement.

Petitioners also argue that the abortion restrictions are necessary to preserve hospital capacity, while Respondents point out that legal abortions are safe and almost never require hospitalization, and abortion care is substantially less likely to lead to hospitalization than caring for a patient with respect to full term pregnancy, childbirth, and post-natal care.

Finally, Petitioners argue that GA-09 as understood to ban all abortions provides the benefit of restricting contact between patients, medical staff, and physicians to help prevent the spread of COVID-19. While this may be true, the language of GA-09 reveals that it was not adopted to serve this interest. GA-09 exempts "any procedure . . . that would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster." It excludes all forms of medical care save "surgeries and procedures," and therefore does not contemplate restricting any other type of medical care that results in contact between providers and patients. Restricting contact between abortion providers and their patients cannot further the goals of GA-09 if the same order permits in-person contact between providers and patients in other settings.

Petitioners suggest that, in addition to these reasons, "Plaintiffs have identified no substantial burdens that will result from delaying elective

abortions in accordance with [GA-09]." The majority agrees, concluding that "the expiration date makes GA-09 a delay, not a ban." Maj. Op. at 19. But it is painfully obvious that a delayed abortion procedure could easily amount to a total denial of that constitutional right: If currently scheduled abortions are postponed, many women will miss the small window of opportunity they have to access a legal abortion. Texas generally prohibits abortion after twenty-two weeks from the first day of the pregnant person's last menstrual period ("LMP"), *see* TEX. HEALTH & SAFETY CODE § 171.044, and therefore GA-09 has the potential to deny a woman's constitutional right to an abortion where that right will lapse during the duration of GA-09. A woman has only a small window of opportunity to exercise her constitutional right to choose, and therefore Petitioners' action in further narrowing that window will present a burden in many cases.

B.

First, prohibiting abortions for patients whose pregnancies will, before the expiration of GA-09, reach or exceed twenty-two weeks, the gestational point at which abortion may no longer be provided in Texas, represents "a plain, palpable invasion of rights secured by the fundamental law." *Jacobson*, 197 U.S. at 31. Even if such state action is successful in conserving the minimal PPE utilized in such procedures, as applied to this group of people, the state's action constitutes an outright ban on previability abortion, which is "beyond question, in palpable conflict with the Constitution." *Id.*; *id.* at 28 (explaining that a state's police power "might be exercised . . . in reference to particular persons in such an arbitrary, unreasonable manner, or might go so far beyond what was reasonably required for the safety of the public, as to authorize or compel the courts to interfere for the protection of such persons"); *see Roe v. Wade*, 410 U.S. 113, 153-54 (1973). Insofar as GA-09 applies to this group of women, then, the district court's result in allowing abortions to

proceed was not patently erroneous. *See In re Lloyd's Register N. Am., Inc.*, 780 F.3d at 290.

Second, insofar as GA-09 bans procedural and medication abortions generally, this act "has no real or substantial relation to" Petitioners' stated goal of conserving PPE and maintaining access to hospital beds and therefore it goes "beyond the necessity of the case, and, under the guise of exerting a police power . . . violate[s] rights secured by the Constitution." *See Jacobson*, 197 U.S. at 28, 31. In particular, abortions require minimal PPE (and medication abortions require no PPE to administer the medication), do not require the use of N95 respirator masks, and rarely require hospitalization. And as Respondents point out, the medical resources conserved by prohibiting abortions would simply be otherwise consumed through prenatal care by women forced to continue their pregnancies or incentivize women to travel out of state to obtain abortions, facilitating the spread of the virus. Finally, even assuming that delayed abortions in fact conserve PPE, Respondents have not demonstrated how the PPE could realistically be reallocated to healthcare workers fighting COVID-19.

Petitioners have, therefore, failed to establish that the district court "reached a patently erroneous result" in temporarily restricting Texas's ability to enforce GA-09 insofar as it bans all procedural and medication abortions. *See In re Lloyd's Register N. Am., Inc.*, 780 F.3d at 290. Mandamus relief should be denied.

* * *

The district court's result was supported by nearly 50 years of Supreme Court precedent protecting a woman's right to choose, and as such I would not conclude that it was patently erroneous. In a time where panic and fear already consume our daily lives, the majority's opinion inflicts further panic and fear on women in Texas by depriving them, without justification, of their

constitutional rights, exposing them to the risks of continuing an unwanted pregnancy, as well as the risks of travelling to other states in search of time-sensitive medical care.

I respectfully but emphatically dissent.

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 20-50264

In re: GREGG ABBOTT, in his official capacity as Governor of Texas; KEN PAXTON, in his official capacity as Attorney General of Texas; PHIL WILSON, in his official capacity as Acting Executive Commissioner of the Texas Health and Human Services Commission; STEPHEN BRINT CARLTON, in his official capacity as Executive Director of the Texas Medical Board; KATHERINE A. THOMAS, in her official capacity as the Executive Director of the Texas Board of Nursing,

Petitioners

Petition for a Writ of Mandamus
to the United States District Court for the
Western District of Texas

Before DENNIS, ELROD, and DUNCAN, Circuit Judges.

PER CURIAM:

IT IS ORDERED that the district court's order of March 30, 2020 (Dkt. No. 40) is TEMPORARILY STAYED until further order of this court to allow this court sufficient time to consider petitioners' emergency motion for stay and petition for writ of mandamus.

IT IS FURTHER ORDERED that plaintiffs-respondents be directed to file a response to the emergency motion for stay no later than Wednesday, April 1, 2020, at 8:00 a.m. Any reply by petitioners is due no later than Wednesday, April 1, 2020, at 8:00 p.m.

IT IS FURTHER ORDERED that plaintiffs-respondents be directed to file a response to the petition for writ of mandamus no later than Thursday, April 2, 2020, at 8 p.m. Any reply by petitioners is due no later than Friday, April 3, 2020, at 5 p.m.

IT IS FURTHER ORDERED that the filing of an amicus brief by States, Alabama, Arkansas, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, and West Virginia, is allowed.

JAMES L. DENNIS, Circuit Judge, dissenting:

A federal judge has already concluded that irreparable harm would flow from allowing the Executive Order to prohibit abortions during this critical time. I would deny the stay. Moreover, I write separately to make clear that, per the Executive Order, "any procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster" is exempt.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, PLANNED PARENTHOOD OF GREATER TEXAS SURGICAL HEALTH SERVICES, PLANNED PARENTHOOD SOUTH TEXAS SURGICAL CENTER, WHOLE WOMAN'S HEALTH, WHOLE WOMAN'S HEALTH ALLIANCE, SOUTHWESTERN WOMEN'S SURGERY CENTER, BROOKSIDE WOMEN'S MEDICAL CENTER PA D/BA BROOKSIDE WOMEN'S HEALTH CENTER AND AUSTIN'S WOMEN'S HEALTH CENTER, AND ROBIN WALLACE, M.D., M.A.S., PLAINTIFFS,	§	
V.	§	CAUSE NO. A-20-CV-323-LY
GREG ABBOTT, GOVERNOR OF TEXAS, KEN PAXTON, ATTORNEY GENERAL OF TEXAS, PHIL WILSON ACTING EXECUTIVE COMMISSIONER OF THE TEXAS HEALTH AND HUMAN SERVICES COMMISSION, STEPHEN BRINT CARLTON, EXECUTIVE DIRECTOR OF THE TEXAS MEDICAL BOARD, KATHERINE A. THOMAS, EXECUTIVE DIRECTOR OF THE TEXAS BOARD OF NURSING, EACH IN THEIR OFFICIAL CAPACITY, AND MARGARET MOORE, DISTRICT ATTORNEY FOR TRAVIS COUNTY, JOE GONZALES, CRIMINAL DISTRICT ATTORNEY FOR BEXAR COUNTY, JAIME ESPARZA, DISTRICT ATTORNEY FOR EL PASO COUNTY, JOHN CREUZOT, DISTRICT ATTORNEY FOR DALLAS COUNTY, SHAREN WILSON, CRIMINAL	§	

DISTRICT ATTORNEY TARRANT	§
COUNTY, RICARDO RODRIGUEZ, JR.,	§
CRIMINAL DISTRICT ATTORNEY	§
FOR HIDALGO COUNTY, BARRY	§
JOHNSON, CRIMINAL DISTRICT	§
ATTORNEY FOR MCLENNAN	§
COUNTY, KIM OGG, CRIMINAL	§
DISTRICT ATTORNEY FOR HARRIS	§
COUNTY, AND BRIAN MIDDLETON	§
CRIMINAL DISTRICT ATTORNEY	§
FOR FORT BEND COUNTY, EACH IN	§
THEIR OFFICIAL CAPACITY,	§
DEFENDANTS.	§

ORDER GRANTING PLAINTIFFS' REQUEST FOR TEMPORARY RESTRAINING ORDER

Before the court is the above styled and numbered cause. Plaintiffs include several licensed abortion facilities, Robin Wallace, a board-certified family medicine physician who provides abortion care and is co-medical director at Southwestern Women's Surgery Center, who bring this action on behalf of herself and her patients, and other organizations that provide abortion services in the State of Texas. Plaintiffs bring this constitutional challenge, pursuant to Title 42 United States Code section 1983, following the publication of a March 23, 2020 press release by the Texas attorney general titled, "Health Care Professionals and Facilities, Including Abortion Providers, Must Immediately Stop All Medically Unnecessary Surgeries and Procedures to Preserve Resources to Fight COVID-19 Pandemic."[1] The press release interprets the governor of Texas's "Executive Order GA-09 relating to hospital capacity during the COVID-19 disaster" ("Executive Order") signed

[1] *Available at* https://www.texasattorneygeneral.gov/news/releases/health-care-professions-and-facilities-including-abortion-providers-must-immediately-stop-all.

March 22, 2020.[2] To the extent the attorney general's interpretation is consistent with the Executive Order, Plaintiffs challenge the Executive Order itself. Plaintiffs also challenge the Texas Medical Board's emergency amendment to Title 22 Texas Administrative Code section 187.57 ("Emergency Rule"), which imposes the same requirements as the Executive Order.[3] The Executive Order remains in effect until 11:59 PM on April 21, 2020, at the earliest, or until the governor rescinds or modifies it.

Pending now before the court is Plaintiffs' Motion for Temporary Restraining Order and/or Preliminary Injunction filed March 25, 2020 (Clerk's Document No. 7). The court held a telephone conference on March 26, 2020, at which Plaintiffs and several Defendants participated by counsel. The court granted the State Defendants'[4] request to file a written response to the motion. The State

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[2] *Available at* https://gov.texas.gov/news/post/govorner-abbott-issues-executive-order-increasing-hospital-capacity-announces-supply-chain-strike-force-for-COVID-19-response. Under the Emergency Management Chapter of the Texas Government Code, "the governor may issue executive orders, proclamations, and regulations and amend or rescind them. Executive orders, proclamations, and regulations have the force and effect of law." Tex. Gov't Code Ann. § 418.012 (West 2019).

[3] *Available at* https://tinyurl.com/v4pz99u. On March 24, 2020, the Texas Medical Board adopted an emergency rule to enforce the Executive Order. Under preexisting law, the Texas Medical Board could temporarily suspend or restrict a physician's license if the physician's "continuation in practice would constitute a continuing threat to the public welfare." 22 Tex. Admin. Code § 187.57(b). The Emergency Rule expands this basis for discipline to include "performance of a non-urgent elective surgery or procedure."

Because the Emergency Rule contains the same requirements to postpone surgeries and procedures that are not immediately necessary, Plaintiffs discuss the Emergency Rule together with the Executive Order.

[4] Defendants Greg Abbott, Governor of Texas, Ken Paxton, Attorney General of Texas, Phil Wilson, Acting Executive Commissioner of the Texas Health and Human Services Commission, Stephen Brint Carlton, Executive Director of the Texas Medical Board, Katherine A. Thomas, Executive Director of the Texas Board of Nursing, each in their official capacity, are referred to as "State Defendants."

Defendants responded March 30, 2020 (Clerk's Document No. 30), and Plaintiffs filed a Supplemental Statement In Support of Motion For Temporary Restraining Order the same day (Clerk's Document No. 29).

Plaintiffs argue that they have shown they are entitled to a temporary restraining order following the attorney general's press release. Plaintiffs interpret the press release as "suggesting that [the attorney general] believes continuing to provide *any* abortion care (other than for an immediate medical emergency) would violate the Executive Order, and as a warning to abortion providers that '[t]hose who violate the [Executive O]rder will be met with the full force of the law.'" The Executive Order provides that failure to comply is a criminal offense punishable by a fine of up to $1,000, confinement in jail for up to 180 days, or both fine and confinement. *See* Tex. Gov't Code Ann. § 418.173 (West 2019) ("Penalty for Violation of Emergency Management Plan"). These criminal penalties also trigger administrative enforcement provisions for the Texas Health and Human Services Commission, the Texas Medical Board, and the Texas Board of Nursing, each of which is authorized to pursue disciplinary action against licensees who violate criminal laws. *See* 25 Tex. Admin. Code §§ 139.32(b)(6), 135.24(a)(1)(F); 22 Tex. Admin. Code § 185.17(11); Tex. Occ. Code Ann. §§ 164.051(a)(2)(B), (a)(6); 301.452(b)(3), (b)(10).

Plaintiffs move for a temporary restraining order that restrains Defendants and their employees, agents, successors, and all others acting in concert or participating with them from enforcing the Executive Order and the Texas Medical Board's Emergency Rule as banning all medication abortions and procedural abortions.

The court, having considered the pleadings, the motion and supporting exhibits, the response, the applicable law, and arguments of counsel, finds and concludes for the specific reasons required

under Federal Rule of Civil Procedure 65(d) and Local Rule 65.01, that Plaintiffs have shown (1) a likelihood of success on the merits, (2) that they will suffer irreparable harm if temporary relief is not granted, (3) that the injury to Plaintiffs outweighs any harm the temporary relief might cause Defendants; and (4) that a temporary restraining order will not disserve the public interest. *See, e.g., Jackson Women's Health Org. v. Currier*, 760 F.3d 448, 452 (5th Cir. 2014) ("*Jackson I*"); *Janvey v. Alguire*, 647 F.3d 585, 595 (5th Cir. 2011).

Substantial likelihood of success on the merits

Specifically, the court finds that Plaintiffs have established a substantial likelihood of success on the merits of their claim that the Executive Order, as interpreted by the attorney general, violates Plaintiffs' patients' Fourteenth Amendment rights, which derive from the Bill of Rights, by effectively banning all abortions before viability. *See Planned Parenthood v. Casey*, 505 U.S. 833, 848-49 (1992) (citing *Griswold v. Conn.*, 381 U.S. 479, 481-82(1965); *Roe v. Wade*, 410 U.S. 113, 153–54 (1973)). The Due Process Clause of the Fourteenth Amendment to the United States Constitution protects a woman's right to choose abortion, *Roe v. Wade*, 410 U.S. 113, 153–54 (1973), and before fetal viability outside the womb, a state has *no interest* sufficient to justify an outright ban on abortions. *Roe*, 410 U.S. at 163–65; *see also Casey*, 505 U.S. at 846, 871 (1992) (reaffirming *Roe*'s "central principle" that "[b]efore viability, the State's interests are not strong enough to support a prohibition of abortion"); *Jackson Women's Health Org. v. Dobbs*, 951 F.3d 246, 248 (5th Cir. 2020) (per curiam) ("*Jackson III*"); *Jackson Women's Health Org. v. Dobbs*, 945 F.3d 265, 268–69 (5th Cir. 2019) ("*Jackson II*").

Under the attorney general's interpretation, the Executive Order either bans all non-emergency abortions in Texas or bans all non-emergency abortions in Texas starting at 10 weeks of

pregnancy, and even earlier among patients for whom medication abortion is not appropriate. Either interpretation amounts to a previability ban which contravenes Supreme Court precedent, including *Roe*. *See, e.g., Jackson III*, 951 F.3d at 248 (*ban* on abortions starting at six weeks). Previability abortion bans are "unconstitutional under Supreme Court precedent without resort to the undue burden balancing test." *Id.* States "may regulate abortion procedures prior to viability so long as they do not impose an undue burden on the woman's right, but they may not ban abortions." *Jackson II*, 945 F.3d at 269.

The State Defendants well describe the emergency facing this country at the present time. They do not overstate when they say, "Texas faces it worst public health emergency in over a century." The Executive Order, as written, does not exceed the governor's power to deal with the emergency. But the attorney general's interpretation of that order constitutes the threat of criminal penalties against those whose interpretation differs. Yes, the attorney general is not the enforcer of those penalties, but many of those who are charged with enforcement are named as defendants in this action. The court takes notice that the opinion or notion of the attorney general as to the breadth of a law, even if expressed informally, carries great weight with those who must enforce it.

Regarding a woman's right to a pre-fetal-viability abortion, the Supreme Court has spoken clearly. There can be no outright ban on such a procedure. This court will not speculate on whether the Supreme Court included a silent "except-in-a-national-emergency clause" in its previous writings on the issue. Only the Supreme Court may restrict the breadth of its rulings. The court will not predict what the Supreme Court will do if this case reaches that Court. For now, the State Defendants, and perhaps the others, agree that the Executive Order bans all pre-fetal-viability abortions. This is inconsistent with Supreme Court precedent. Plaintiffs have demonstrated a strong likelihood of success on the merits of their action.

Plaintiffs will suffer irreparable harm

Plaintiffs' patients will suffer serious and irreparable harm in the absence of a temporary restraining order. The attorney general's interpretation of the Executive Order prevents Texas women from exercising what the Supreme Court has declared is their fundamental constitutional right to terminate a pregnancy before a fetus is viable. It is well established that, upon a plaintiff's demonstrating a constitutional violation, no further irreparable injury is necessary. *See Elrod v. Burns*, 427 U.S. 347, 373 (1976) ("The loss of [constitutional] freedoms . . . unquestionably constitutes irreparable injury."); *Opulent Life Church v. City of Holly Springs*, 697 F.3d 279, 295 (5th Cir. 2012); *Deerfield Med. Ctr. v. City of Deerfield Beach*, 661 F.2d 328, 338 (5th Cir. Unit B Nov. 1981).

The threatened injury to Plaintiffs outweigh any damage the temporary restraining order may cause Defendants

A delay in obtaining abortion care causes irreparable harm by "result[ing] in the progression of a pregnancy to a stage at which an abortion would be less safe, and eventually illegal." *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 796 (7th Cir. 2013). This "disruption or denial of . . . patients' health care cannot be undone after a trial on the merits." *Planned Parenthood of Kan. v. & Mid Mo. v. Andersen*, 882 F.3d 1205, 1236 (10th Cir. 2018). For some patients, such a delay will deprive them of any access to abortion. *See* Tex. Health & Safety Code Ann. § 171.044 (West 2017) (prohibiting abortions after 20 or more weeks post-fertilization age). The court finds that the threatened injury to Plaintiffs outweighs any damage the temporary restraining order may cause Defendants.

Temporary restraining order will not disserve the public interest

"The grant of an injunction will not disserve the public interest . . . when an injunction is designed to avoid constitutional deprivations." *Jackson's Woman's Health Org. v. Currier*, 940 F. Supp. 2d 416, 424 (S.D. Miss. 2013), *aff'd*, 760 F.3d 448 (5th Cir. 2014). Plaintiffs' requested relief will essentially continue the *status quo*, tipping the balance of equities toward Plaintiffs and serving the public interest. *Id.*; *United States v. Tex.*, 508 F.2d 98, 101 (5th Cir. 1975). The benefits of a limited potential reduction in the use of some personal protective equipment by abortion providers is outweighed by the harm of eliminating abortion access in the midst of a pandemic that increases the risks of continuing an unwanted pregnancy, as well as the risks of travelling to other states in search of time-sensitive medical care. The court finds that a temporary restraining order will not disserve the public interest.

The court concludes that Plaintiffs have shown that they are entitled to a temporary restraining order. Therefore,

IT IS ORDERED that Plaintiffs' Motion for Temporary Restraining Order filed March 25, 2020 (Clerk's Document No. 7) is **GRANTED**.

IT IS FURTHER ORDERED that Defendants and their employees, agents, successors, and all others acting in concert or participating with them, are **TEMPORARILY RESTRAINED** from enforcing Executive Order GA-09, "Relating to hospital capacity during the COVID-19 disaster," and the Texas Medical Board's emergency amendment to Title 22 Texas Administrative Code section 187.57, as applied to medication abortions and procedural abortions.[5]

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[5] Pursuant to an Agreed Stipulation for Non-Enforcement Pending Final Resolution, Attorneys Fees and Costs filed March 28, 2020 (Clerk's Document No. 25) this order does not apply to Defendant Brian Middleton, Criminal District Attorney for Fort Bend County.

IT IS FURTHER ORDERED that this Temporary Restraining Order shall expire on April 13, 2020 at 3:00 p.m. This order may be extended for good cause, pursuant to Federal Rule of Civil Procedure 65.

Plaintiffs have also moved for a preliminary injunction. Therefore,

IT IS ORDERED that the hearing on Plaintiffs' motion for a preliminary injunction is set for a telephonic hearing on April 13, 2020 at 9:30 a.m. Counsel and parties may call in to the court's conference line at (877) 873-8017, with Access Code 7996289.

Plaintiffs shall not be required to post a bond. *See Kaepa, Inc. v. Achilles Corp.*, 76 F.3d 624, 628 (5th Cir. 1996).

SIGNED at 3:00 p.m. .m., this 30th day of March, 2020.

LEE YEAKEL
UNITED STATES DISTRICT JUDGE

GOVERNOR GREG ABBOTT

March 22, 2020

FILED IN THE OFFICE OF THE
SECRETARY OF STATE
4:30 PM O'CLOCK
MAR 22 2020
Secretary of State

The Honorable Ruth R. Hughs
Secretary of State
State Capitol Room 1E.8
Austin, Texas 78701

Dear Secretary Hughs:

Pursuant to his powers as Governor of the State of Texas, Greg Abbott has issued the following:

> Executive Order No. GA-09 relating to hospital capacity during the COVID-19 disaster.

The original executive order is attached to this letter of transmittal.

Respectfully submitted,

Gregory S. Davidson
Executive Clerk to the Governor

GSD/gsd

Attachment

Executive Order

BY THE
GOVERNOR OF THE STATE OF TEXAS

Executive Department
Austin, Texas
March 22, 2020

EXECUTIVE ORDER
GA 09

Relating to hospital capacity during the COVID-19 disaster.

WHEREAS, I, Greg Abbott, Governor of Texas, issued a disaster proclamation on March 13, 2020, certifying under Section 418.014 of the Texas Government Code that the novel coronavirus (COVID-19) poses an imminent threat of disaster for all counties in the State of Texas; and

WHEREAS, the Texas Department of State Health Services has determined that, as of March 19, 2020, COVID-19 represents a public health disaster within the meaning of Chapter 81 of the Texas Health and Safety Code; and

WHEREAS, on March 19, 2020, I issued an executive order in accordance with the President's Coronavirus Guidelines for America, as promulgated by President Donald J. Trump and the Centers for Disease Control and Prevention (CDC), and mandated certain obligations for Texans that are aimed at slowing the spread of COVID-19; and

WHEREAS, a shortage of hospital capacity or personal protective equipment would hinder efforts to cope with the COVID-19 disaster; and

WHEREAS, hospital capacity and personal protective equipment are being depleted by surgeries and procedures that are not medically necessary to correct a serious medical condition or to preserve the life of a patient, contrary to recommendations from the President's Coronavirus Task Force, the CDC, the U.S. Surgeon General, and the Centers for Medicare and Medicaid Services; and

WHEREAS, various hospital licensing requirements would stand in the way of implementing increased occupancy in the event of surge needs for hospital capacity due to COVID-19; and

WHEREAS, the "governor is responsible for meeting . . . the dangers to the state and people presented by disasters" under Section 418.011 of the Texas Government Code, and the legislature has given the governor broad authority to fulfill that responsibility; and

WHEREAS, under Section 418.012, the "governor may issue executive orders . . . hav[ing] the force and effect of law;" and

WHEREAS, under Section 418.016(a), the "governor may suspend the provisions of any regulatory statute prescribing the procedures for conduct of state business or the orders or rules of a state agency if strict compliance with the provisions, orders, or rules would in any way prevent, hinder, or delay necessary action in coping with a disaster;" and

FILED IN THE OFFICE OF THE SECRETARY OF STATE
4:39 PM O'CLOCK
MAR 22 2020

WHEREAS, under Section 418.173, failure to comply with any executive order issued during the COVID-19 disaster is an offense punishable by a fine not to exceed $1,000, confinement in jail for a term not to exceed 180 days, or both fine and confinement.

NOW, THEREFORE, I, Greg Abbott, Governor of Texas, by virtue of the power and authority vested in me by the Constitution and laws of the State of Texas, do hereby order that, beginning now and continuing until 11:59 p.m. on April 21, 2020, all licensed health care professionals and all licensed health care facilities shall postpone all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician;

PROVIDED, however, that this prohibition shall not apply to any procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster.

At the request of the Texas Health and Human Services Commission, I hereby suspend the following provisions to the extent necessary to implement increased occupancy in the event of surge needs for hospital capacity due to COVID-19:

25 TAC Sec. 133.162(d)(4)(A)(iii)(I);
25 TAC Sec. 133.163(f)(1)(A)(i)(II)–(III);
25 TAC Sec. 133.163(f)(1)(B)(i)(III)–(IV);
25 TAC Sec. 133.163(m)(1)(B)(ii);
25 TAC Sec. 133.163(t)(1)(B)(iii)–(iv);
25 TAC Sec. 133.163(t)(1)(C);
25 TAC Sec. 133.163(t)(5)(B)–(C); and
any other pertinent regulations or statutes, upon written approval of the Office of the Governor.

This executive order shall remain in effect and in full force until 11:59 p.m. on April 21, 2020, unless it is modified, amended, rescinded, or superseded by me or by a succeeding governor.

Given under my hand this the 22nd day of March, 2020.

GREG ABBOTT
Governor

ATTESTED BY:

RUTH R. HUGHS
Secretary of State

FILED IN THE OFFICE OF THE SECRETARY OF STATE
4:39 PM O'CLOCK
MAR 22 2020

March 23, 2020

Health Care Professionals and Facilities, Including Abortion Providers, Must Immediately Stop All Medically Unnecessary Surgeries and Procedures to Preserve Resources to Fight COVID-19 Pandemic

Texas Attorney General Ken Paxton today warned all licensed health care professionals and all licensed health care facilities, including abortion providers, that, pursuant to Executive Order GA 09 issued by Gov. Greg Abbott, they must postpone all surgeries and procedures that are not immediately medically necessary.

On Saturday, Gov. Abbott issued an executive order that "all licensed health care professionals and all licensed health care facilities shall postpone all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician." This prohibition applies throughout the State and to all surgeries and procedures that are not immediately medically necessary, including routine dermatological, ophthalmological, and dental procedures, as well as most scheduled healthcare procedures that are not immediately medically necessary such as orthopedic surgeries or any type of abortion that is not medically necessary to preserve the life or health of the mother.

The COVID-19 pandemic has increased demands for hospital beds and has created a shortage of personal protective equipment needed to protect health care professionals and stop transmission of the virus. Postponing surgeries and procedures that are not immediately medically necessary will ensure that hospital beds are available for those suffering from COVID-19 and that PPEs are available for health care professionals. Failure to comply with an executive order issued by the governor related to the COVID-19 disaster can result in penalties of up to $1,000 or 180 days of jail time.

> **"We must work together as Texans to stop the spread of COVID-19 and ensure that our health care professionals and facilities have all the resources they need to fight the virus at this time," said Attorney General Paxton. "No one is exempt from the governor's executive order on medically unnecessary surgeries and procedures, including abortion providers. Those who violate the governor's order will be met with the full force of the law."**

For information on the spread or treatment of Coronavirus (COVID-19), please visit the Texas Department of State Health Services (https://dshs.texas.gov/coronavirus/) website.

Texas Register

TITLE 22	EXAMINING BOARDS
PART 9	TEXAS MEDICAL BOARD
CHAPTER 187	PROCEDURAL RULES
SUBCHAPTER F	TEMPORARY SUSPENSION AND RESTRICTION PROCEEDINGS
RULE §187.57	Charge of the Disciplinary Panel
ISSUE	04/03/2020
ACTION	Emergency

Preamble

Texas Admin Code Rule

(a)The disciplinary panel shall determine from the evidence or information presented to it whether a person's continuation in practice constitutes a continuing threat to the public welfare.

(b)If the disciplinary panel determines that a person's continuation in practice would constitute a continuing threat to the public welfare, the disciplinary panel shall temporarily suspend or restrict the license of that person.

(c)In accordance with the Act, §151.002(a)(2), "continuing threat to the public welfare," means a real danger to the health of a physician's patients or the public caused through the physician's lack of competence, impaired status, performance of a non-urgent elective surgery or procedure, or failure to care adequately for the physician's patients. A real danger exists if patients have an exposure to or risk of injury that is not merely abstract, hypothetical or remote and is based on actual actions or inactions of the physician. Information that the physician has committed similar actions or inactions in the past shall be considered by the disciplinary panel.

(1)For purposes of this rule all licensed health care professionals shall postpone all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician.

(2)Provided, however, that this prohibition shall not apply to any procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster.

(d)The disciplinary panel may also temporarily restrict or suspend a license of a person upon proof that a person has been arrested for an offense under:

(1)Section 22.011(a)(2), Penal Code (sexual assault of a child);

(2)Section 22.021(a)(1)(B), Penal Code (aggravated sexual assault of a child);

(3)Section 21.02, Penal Code (continuous sexual abuse of a young child or children); or

(4)Section 21.11, Penal Code (indecency with a child).

The agency certifies that legal counsel has reviewed the emergency adoption and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on March 23, 2020

TRD-202001217

Scott Freshour

General Counsel

Texas Medical Board

Effective date: March 23, 2020

Expiration date: July 20, 2020

For further information, please call: (512) 305-7016

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, *et al*., Plaintiffs, v. GREG ABBOTT, in his official capacity as Governor of Texas, *et al*., Defendants.	No. 1:20-cv-00323-LY

DECLARATION OF POLIN C. BARRAZA IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

Polin C. Barraza declares as follows:

1. I am President and Board Chair of Plaintiff Planned Parenthood South Texas Surgical Center ("PPST Surgical Center"), a not-for-profit corporation headquartered in San Antonio. PPST Surgical Center operates a licensed ambulatory surgical center and a licensed abortion facility in San Antonio. PPST Surgical Center provides a range of reproductive health services, including medication and surgical abortions.

2. I am responsible for the management of PPST Surgical Center (as well as the operations of its parent organization, Planned Parenthood South Texas), and therefore am familiar with our operations and finances, including the services we provide and the communities we serve.

3. I submit this declaration in support of Plaintiffs' motion for a temporary restraining order followed by a preliminary injunction, which seeks to enjoin Executive Order

No. GA-09, as interpreted by the Texas Attorney General to ban all previability abortion in the state except where immediately necessary to protect the life or health of a pregnant person, as well as the Texas Medical Board's emergency amendment to 22 TAC § 187.57 ("Emergency Rule"), which imposes the same requirements as the Executive Order. I am familiar with the Executive Order, a press release by the Texas Attorney General interpreting it, and the Emergency Rule. PPST Surgical Center has adopted a policy to implement the Executive Order, a true and correct copy of which is attached as Exhibit A.

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

PPST Surgical Center's Provision of Abortion Care

5. In 2019 PPST Surgical Center provided 1855 abortions, and of those, 1258 were medication abortions and 597 were surgical abortions.

6. In January and February 2020, PPST Surgical Center performed 550 abortions, and of those, 396 were medication abortions and 154 were surgical abortions.

7. Neither medication nor surgical abortion requires extensive PPE or otherwise would deplete PPE. In fact, for medication abortion, providing patients with the medication does not require the use of *any* PPE. And while surgical abortion at PPST Surgical Center requires the use of sterile gloves for each procedure, a surgical mask that includes protective eyewear (one per provider per day, unless a mask becomes soiled), disposable gowns (one per provider per

day, unless a gown becomes soiled), disposable hair and shoe covers, and reuable lab coats and face shields, only a small number of workers are physically present for these procedures or their preparation/recovery and therefore in need of PPE.[1] PPST uses only non-sterile gloves or condoms to perform ultrasound or laboratory exam, including one that accompanies medication or surgical abortion.

8. PPST Surgical Center does not use or have any N95 respirators, which I understand are the PPE in shortest supply during the COVID-19 pandemic.

9. PPST Surgical Center does not provide inpatient care, nor is it set up to do so.

PPST Surgical Center's Efforts to Prevent COVID-19 Spread and Conserve Needed Resources

10. PPST Surgical Center is committed to doing its part to reduce the spread of COVID-19 and to otherwise help ensure that our public health system has sufficient resources to meet the challenge of responding to a potential surge of illness.

11. Since the COVID-19 outbreak, PPST Surgical Center has taken steps to preserve much-needed medical resources that are in short supply during the pandemic. Even before the Governor's Executive Order, for example, we had excluded residents and medical students from observing or participating in surgeries or procedures, which reduced the number of individuals requiring PPE.

12. We have also taken numerous steps to help prevent the spread of COVID-19 infection in the communities where we offer services. Although in normal times we welcome support companions accompanying abortion patients, we have decided not to allow such

[1] Per CDC guidance, Plaintiffs provide patients for whom there is a concern for COVID-19 or other upper respiratory disease with a mask.

companions (except parents accompanying minors) to enter our health centers in order to reduce the number of overall people exposed to one another.

13. We have also made dramatic changes to the flow of our patient care. Before patients may enter a health center, we screen them for COVID-19 symptoms. Only those individuals who are positively screened can proceed to the front desk to check in and provide their phone number. Patients are then asked to wait in their cars, where a medical assistant will contact them to do as much intake as possible by phone. Patients are only permitted to reenter the health center when a room has opened for them and a clinician is available to see them. We have reconfigured our waiting rooms and check-in practices to limit the number of people in our facility, as well as to ensure they can and are maintaining the recommended social-distance.

14. More recently, PPST has curtailed other non-abortion services that can safely be delayed, such as annual well-person visits and routine STI tests.

15. In light of the Executive Order, we have cancelled surgical abortions scheduled for this week, and PPST Surgical Center will cancel non-emergency future surgical abortions appointments unless and until the Executive Order and Emergency Rule expire or are rescinded, or unless the Court grants relief. Additionally, PPST Surgical Center has stopped providing non-emergency medication abortions because of concerns about whether these abortions are permissible under the Attorney General's interpretation of the Executive Order.

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

Executed March 25, 2020

Polin C. Barraza

EXHIBIT A

Planned Parenthood®

Planned Parenthood
Policy In Response to Texas Executive Order GA 09
Relating to Hospital Capacity During the COVID-19 Disaster

PURPOSE

In light of the global pandemic of COVID-19, Governor Abbott signed Executive Order ("EO") GA 09 on March 22, 2020, attached, which is in effect until 11:59 p.m. on April 21, 2020. EO GA 09 directs "all licensed health care professionals and all licensed health care facilities" to "postpone all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician." EO GA 09 goes on to state that this prohibition does not apply to "any procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID- 19 disaster."

POLICY

To comply with EO GA 09, Planned Parenthood hereby establishes the following policies which shall remain in effect until rescinded or modified:

1. Surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician, and which would deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster, are not to be scheduled while this policy is in effect.

2. Physicians shall determine on a case-by-case basis whether a procedure that would deplete hospital capacity or personal protective equipment needed to cope with COVID-19 can be delayed without risk for serious adverse medical consequences or death.

3. Planned Parenthood physicians have made the determination that abortion is a time-sensitive service and an essential component of comprehensive care, for which a delay of 30 days, or even less, increases the risks to patients, or make abortion completely inaccessible, and that such delay in accessing or inability to access an abortion exposes patients to risk of a serious adverse medical consequence.

4. In making this determination, Planned Parenthood physicians considered or will consider the following:

a. The purpose and text of EO GA 09, namely: concern for "a shortage of hospital capacity or personal protective equipment" that could "hinder efforts to cope with the COVID-19 disaster."

b. The stated 30-day duration of a the delay, taking into account the Ambulatory Surgery Center Association's "COVID-19: Guidance for ASCs for Necessary Surgery," issued March 18, 2020, which states that consideration of whether delay of a surgery is appropriate must account for risk to the patient of delay, "including the expectation that a delay of 6–8 weeks or more may be required to emerge from an environment in which COVID-19 is less prevalent."

c. The fact that pregnancy has a duration of approximately forty weeks, as measured from the first day of a woman's last menstrual period (LMP) and that most abortions are banned in Texas beginning at 20 weeks gestation. Tex. Health & Safety Code § 171.044.

d. The fact that, while abortion is an extremely safe medical procedure, delay increases the risk to the health of the patient. *See, e.g.,* Nat'l Acads. of Scis. Eng'g & Med., The Safety & Quality of Abortion Care in the United States at 77-78, 162-63 (2018). Delay is of particular concern during the COVID-19 crisis, given guidance from the Center for Disease Control ("CDC") and American College of Obstetricians and Gynecologists ("ACOG") that pregnant women may be at heightened risk of severe illness, morbidity, or mortality from viral respiratory infections such as COVID-19.[1]

e. The Joint Statement by the American College of Obstetricians and Gynecologists ("ACOG"), the American Association of Gynecologic Laparoscopists, *et al.*, on Elective Surgeries[2], issued March 16, 2020, which states that "Obstetric and gynecologic procedures for which a delay will negatively affect patient health and safety should not be delayed. This includes gynecologic procedures and procedures related to pregnancy for which delay would harm patient health. Obstetrician–

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[1] Available at https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/03/novel-coronavirus-2019 and https://www.cdc.gov/coronavirus/2019-ncov/hcp/pregnant-women-faq.html

[2] Available at https://www.acog.org/news/news-releases/2020/03/joint-statement-on-elective-surgeries

gynecologists and other health care practitioners should be aware of the unintended impact that policies responding to COVID-19 may have, including limiting access to time-sensitive obstetric and gynecological procedures."

f. The Joint Statement by the ACOG, the American Board of Obstetrics & Gynecology, *et al.*, on Abortion Access During the COVID-19 Outbreak[3], issued March 18, 2020, which states that to "the extent that hospital systems or ambulatory surgical facilities are categorizing procedures that can be delayed during the COVID-19 pandemic, abortion should not be categorized as such a procedure" because it "is an essential component of comprehensive health care" and "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks [to patients] or potentially make it completely inaccessible."

3. All procedures which cannot be reasonably delayed and thus which *are* scheduled and performed, in accordance with the above considerations and in compliance with EO GA 09, shall be performed while making every effort to conserve PPE and to reduce the possibility of spread and transmission of COVID-19.

[3] Available at https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak

Planned Parenthood®

Parenthood Policy In Response to the Texas Executive Order GA 09 Policy Relating to Hospital Capacity During the COVID-19 Disaster has been reviewed and approved by:

Polin C. Barraza
President & Chair

3.24.20
Date

Gerard Honoré, MD
Medical Director

3/24/20
Date

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, et al., Plaintiffs, v. GREG ABBOTT, in his official capacity as Governor of Texas, et al., Defendants.	No. 1:20-cv-00323-LY

DECLARATION OF MARY TRAVIS BASSETT, M.D., M.P.H., IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Mary Travis Bassett, M.D., M.P.H. declare as follows:

1. I am the Director of the François-Xavier Bagnoud ("FXB") Center for Health and Human Rights at Harvard University, as well as the FXB Professor of the Practice of Health and Human Rights at the Harvard T.H. Chan School of Public Health. I am offering this declaration on my own behalf and not on that of Harvard University or other professional organizations that are noted.

2. I served as Commissioner of the New York City Department of Health and Mental Hygiene (DOHMH) from 2014–2018 and led New York's response to the Ebola pandemic. I also led DOHMH as the City responded to a large outbreak of Legionnaires' disease and the Zika outbreak in South America and the Caribbean. Previously, I had been the Program Director for the African Health Initiative and the Child Well-Being Program at the Doris Duke Charitable Foundation (2009–2014). Prior to that, I served as Deputy Commissioner of Health Promotion and Disease Prevention, for the New York City Department of Health and Mental Hygiene (2002–2009).

3. My awards and honors include the Frank A. Calderone Prize in Public Health, a Kenneth A. Forde Lifetime Achievement Award from Columbia University, a Victoria J. Mastrobuono Award for Women's Health, and the National Organization for Women's Champion of Public Health Award. I am an elected a member of the National Academy of Medicine. For over a decade, I served as an associate editor of the American Journal of Public Health. My recent publications include articles in The Lancet and in the New England Journal of Medicine addressing structural racism and health inequities in the United States. My complete curriculum vitae is attached as Exhibit A.

4. I am a member of the National Academies of Sciences, Engineering and Medicine Standing Committee on Emerging Infectious Diseases and 21st Century Health Threats, a group of experts established at the request of Office of Science and Technology Policy (OSTP) and the Office of the Assistant Secretary for Preparedness and Response (ASPR), to help inform the federal government on critical science and policy issues related to emerging infectious diseases and other twenty-first century health threats, currently focused on COVID-19. *See* Nat'l Acads. of Scis., Eng'g & Med., Standing Committee on Emerging Infection Diseases and 21st Century Health Threats (last updated Mar. 28, 2020), https://www.nationalacademies.org/our-work/standing-committee-on-emerging-infectious-diseases-and-21st-century-health-threats#sectionPublications. My areas of teaching and research include focus on reducing socio-economic and racial inequalities in health. I have written several newspaper perspectives on the COVID-19 pandemic, including in the Washington Post and New York Times, where I note the racial and economic disparities in vulnerability to COVID-19.

5. I have reviewed the Declaration of Joshua Sharfstein, M.D., in Support of Plaintiffs' Motion for Preliminary Injunction, and I agree with the opinions set forth therein.

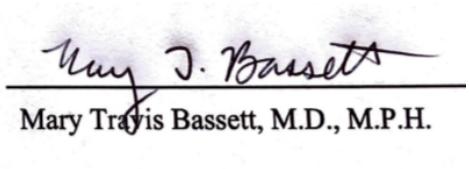
6. My recent service as Commissioner of DOHMH underscores the reasons why Texas's implementation of its executive order is profoundly misguided as a public health measure aimed at conserving personal protective equipment ("PPE") and hospital resources. New York City is the current epicenter of the COVID-19 pandemic in the United States, and the public health challenges of the crisis are very real. But for all of the reasons explained in Dr. Sharfstein's declaration, prohibiting abortion services is not an effective way to conserve PPE or hospital resources. Even aside from the harm to the patients who are denied access to timely care, patients who are forced to obtain a procedure later in pregnancy are likely to have a procedure that requires the use of more PPE. And if patients travel to another state to try to end their pregnancies, again PPE is not conserved.

7. Implementing a public health policy that increases the likelihood that patients will travel to try to get an abortion elsewhere is particularly counterproductive. The single most effective thing people can do to slow the spread of COVID-19 and "flatten the curve" is to avoid unnecessary contact and travel. Over two dozen states have issued "shelter in place" or "stay at home" orders in order to accomplish this. And if patients succeed in obtaining an abortion in another state, then of course there has been no net savings of PPE. To the contrary, by potentially exposing patients and others with whom they come in contact to increased risk of contagion, the net effect of forcing patients to travel is to deplete both PPE and other hospital resources.

8. In the years before abortion was available in every state, patients who were able to do so traveled from across the country to obtain an abortion in New York City. The prospect of large numbers of patients traveling from Texas to other states during the current pandemic crisis is truly frightening from a public health perspective.

9. Access to health care varies by income and employment status and contributes to longstanding disparities in health status. While inadvisable from a public health perspective to travel to seek care during the COVID-19 outbreak, only patients with the resources required to do so will have this option. This means that resources and not a woman's preference may determine access to care.

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



Mary Travis Bassett, M.D., M.P.H.

Executed on: April 2, 2020

EXHIBIT A

CURRICULUM VITAE

Date of preparation January 28, 2020

Personal Data

Name: Mary Travis Bassett
Citizenship: United States Citizen
Address: [redacted]
Tel: 617-432-4750 (work)
[redacted]
Fax: 617-432-4310 (work)
E-mail: mbassett@hsph.harvard.edu (work)
[redacted]

Academic Training

June 1985	M.P.H., University of Washington Seattle, Washington
May 1979	M.D., Columbia College of Physicians and Surgeons New York, New York
June 1974	A.B., Cum Laude, History and Science, Radcliffe College Cambridge, Massachusetts

Traineeships

1983-1985	Robert Wood Johnson Clinical Scholar University of Washington Seattle, Washington
1982-1983	Chief Resident, Department of Medicine Harlem Hospital Center New York, New York
1979-1982	Residency Training, Internal Medicine Harlem Hospital Center New York, New York

Board Certification and Licensure

Board Qualification

1983	Diplomate, American Board of Internal Medicine Candidate 089171

Licensure

1981	New York (active)

Committees, Professional Organizations and Societies

Member	National Academy of Medicine (inducted 2018)
Member	The Center for Climate, Health, and the Global Environment at Harvard T.H. Chan School of Public Health (Harvard C-CHANGE) (2020-present).
Member	Tobacco Products Scientific Advisory Committee, Food and Drug Administration (February 2018-August 31 2018)
Member	National Academy of Medicine (2017-present)
Member	Advisory Board, New York University College of Global Public Health (2017-present)
Member	Board of Directors, Truth Initiative (2017-present)
Member	External Advisory Board, NYU School of Medicine, Department of Population Health (2016-present)
Chair	NYC Board of Health (2014-2018)
Chair and President	Board of Directors, Fund for Public Health in New York City (2014-2018)
Member	Committee on Planning the Assessment/Evaluation of HIV/AIDS Programs Implemented Under United States Global Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008 (2008-2013)
Associate Editor	American Journal of Public Health (2002- 2014)
International Editor	American Journal of Public Health (2000- 2002)
Member	American Public Health Association (1998-present)

Academic Appointments/Employment

2018- present	Director and FXB Professor of Public Health Practice Francois-Xavier Bagnoud Center for Health and Human Rights at Harvard University Harvard T.H. Chan School of Public Health Boston, Massachusetts
2014- 2018	Commissioner New York City Department of Health and Mental Hygiene New York, New York

2009-2014	Program Director African Health Initiative and Child Well-Being Prevention Program Doris Duke Charitable Foundation New York, New York
2002-2009	Deputy Commissioner, Health Promotion and Disease Prevention New York City Department of Health and Mental Hygiene New York, New York
2001-2002	Associate Director, Health Equity Rockefeller Foundation Southern Africa Office
1995-2018	Associate Professor, Clinical Public Health and Clinical Medicine Columbia University, College of Physicians and Surgeons (on leave) New York, New York
1985-2005	Department of Community Medicine University of Zimbabwe Harare, Zimbabwe 1985-1991 Lecturer 1992-2000 Senior Lecturer (on leave 1987-88, 1995-97) 2000-2005 Associate Professor (on leave 2001-05)
1997-2001	Research Associate, Department of Medicine Stanford University Medical Center Stanford, California
1995-1997	Director, Harlem Center for Disease Prevention Columbia School of Public Health New York, New York
1987-1988	Attending Physician, Department of Medicine Harlem Hospital Center New York, New York

Honors

2019	Public Health Hall of Fame. *Public Health Solutions*
2019	Stephen Smith Award. New York Academy of Medicine
2019	Elisabeth B. Weintz Humanitarian Award, Harvard Humanitarian Initiative
2018	Notable Women in Health Care, *Crain's New York Business*

2018	John Dewey Award for Distinguished Service, Bard Prison Initiative
2017	Kenneth A. Forde Lifetime Achievement Award, Columbia University
2017	Baseball Leadership Award, Arthur Ashe Institute for Urban Health
2017	Beny J. Primm Humanitarian Award, START
2017	Honoree, VOCAL-NY
2017	Victoria J. Mastrobuono Award for Women's Health, National Organization for Women
2017	Champion of Public Health, City University of New York, School of Public Health
2017	Fuerza Award, Latino Commissioner on AIDS
2016	Sapientia et Doctrina Medal, Fordham University
2016	Frank A. Calderone Prize in Public Health, Columbia University, Mailman School of Public Health
2016	Founders' Award, Citizens' Committee for Children of New York
2016	Marshall England Memorial Pubic Health Award, Commission on the Public's Health System
2014	Public Health Leadership Award, Treatment Action Group
2014	Lucille Bulger Community Service Award, Community League of the Heights
2014	Public Service Award, Coalition of Behavioral Health Agencies
2013	Haven Emerson Award, Public Health Association of New York City
1979	Franklin McLean Award for "Best Graduating Black Medical Student," Columbia College of Physicians and Surgeons
1974	Ames Award for "Courage and Leadership," Harvard-Radcliffe

Fellowship and Grant Support

Apr. 1999-Mar. 2003	Targeted Epidemiological Treatment vs. General Population Approaches to STD/HIV prevention. Supported by USAID under the Horizons programme. (David Wilson, Principal Investigator)
Dec. 1999-Jan. 2002	Use of Lay Volunteers in HIV Counselling and Testing among Antenatal Women in Chitungwiza. Supported by Swedish International Development Agency (SIDA) and National Institute of Health, United States
Aug. 1999-Sept. 2001	Factory based AIDS Prevention (FWAPP). Supported by AusAID in collaboration with Australian Overseas Volunteers
Aug. 1999-Sept. 2001	Cost-sharing for peer education in workplace-based AIDS prevention. Supported by the Royal Netherlands Embassy

Nov. 1997-Feb. 2001	Investigator and programme director. Zimbabwe AIDS Prevention Project, a HIVNET (NIH) site
Aug. 1994-Dec. 1995	"User acceptability of over-the-counter vaginal preparations" Population Council. Multicentre study; Zimbabwe (Principal Investigator)
Apr. 1994-Mar. 1995	"Adolescents AIDS Prevention," Ford Foundation
Jan 1993-Jan. 1994	"User acceptability of the female condom in Zimbabwe, awarded by WHO, Special Programme of Research Development and Research Training in Human Reproduction
Apr.1992-Dec. 1994	"Women and AIDS in Zimbabwe: An Ethnographic Study" International Center for Research on Women Washington, District of Columbia
Mar. 1992-Feb. 1995	"Impact of structural adjustment on health in an urban and a rural area of Zimbabwe," funded by Nordic Institute for African Studies. (David M. Sanders, Principal Investigator)
Jan. 1992-Dec. 1994	Preparation for evaluation of AIDS vaccine (PAVE) funded by National Institutes of Health. (David Katzenstein, Principal Investigator)

Consultancy Work

May-Dec. 2000	Team member, AIDS Exploration, Rockefeller Foundation
Nov.1997- Mar.1998	Assessment of the impact of the Family Health Project in collaboration with the Ministry of Health, World Bank
June-July 1997	Team member, Assessment of Malawi AIDS Control Program World Bank
Aug. 1992	Evaluation of Village Community Worker Program in Zimbabwe, Commissioned by UNICEF
Jan. 1992	Review of water- and sanitation-related diseases in Zimbabwe. Commissioned by the World Bank, funded by UNICEF

Publications

Original, peer-reviewed articles

Bassett MT. "Public Health Addresses Police Violence: A Beginning." *American Journal of Public Health* 110, S7_S8, https://doi.org/10.2105/AJPH.2019.305435. January 2020.

Cloud DH, Bassett MT, Graves F, Fullilove RE, Brinkley-Rubinstein L. "2020: Documenting and Addressing the Health Impacts of Carceral Systems." *American Journal of Public Health* 110, S5_S5, https://doi.org/10.2105/AJPH.2019.305475. January 2020.

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Perl SB, Merrill TG, Lopez W, Bassett MT. The Legacy of 1987 *Boreali v. Axelrod:* Board of Health Rule-Making Under Siege. *Am J Public Health.* Published online ahead of print November 29, 2018: e1–e4. doi:10.2105/AJPH.2018.304755.

Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: Evidence and interventions. *Lancet.* 2017; 389(10077): 1453-63.

Tsao TY, Konty KJ, Van Wye G, Barbot O, Hadler JL, Linos N, Bassett MT. Estimating potential reductions in premature mortality in New York City from raising the minimum wage to $15. *Am J Public Health.* 2016; 106(6):1036-41.

Bassett MT, Gallin EK, Adedokun L, Toner C. From the ground up: Strengthening health systems at district level. *BMC Health Serv Res.* 2013; 13(Suppl 2):S2.

Dumanovsky T, Huang CY, Nonas CA, Matte TD, Bassett MT, Silver LD. Changes in energy content of lunchtime purchases from fast food restaurants after introduction of calorie labelling: Cross sectional customer surveys. *BMJ.* 2011; 343:d4464.

Dumanovsky T, Huang CY, Bassett MT, Silver LD. Consumer awareness of fast-food calorie information in New York City after implementation of a menu labeling regulation. *Am J Public Health.* 2010; 100(12):2520-5.

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Huang C, Dumanovsky T, Silver LD, Nonas C, Bassett MT. Calories from beverages purchased at 2 major coffee chains in New York City, 2007. *Prev Chronic Dis.* 2009; 6(4): A118.

Angell SY, Silver LD, Goldstein GP, Johnson CM, Deitcher DR, Frieden TR, Bassett MT. Cholesterol control beyond the clinic: New York City's trans fat restriction. *Ann Intern Med.* 2009 151(2):129-34.

Dumanovsky T, Nonas CA, Huang CY, Silver LD, Bassett MT. What people buy from fast-food restaurants: Caloric content and menu item selection, New York City 2007. *Obesity (Silver Spring).* 2009; 17(7):1369-74.

Cowan FM, Pascoe SJ, Barlow KL, Langhaug LF, Jaffar S, Hargrove JW, Robinson NJ, Bassett MT, Wilson D, Brown DW, Hayes RJ. A randomised placebo-controlled trial to explore the effect of suppressive therapy with acyclovir on genital shedding of HIV-1 and herpes simplex virus type 2 among Zimbabwean sex workers. *Sex Transm Infect.* 2008*;* 84(7):548-53.

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Chokunonga E, Levy LM, Bassett MT, Borok MZ, Mauchaza BG, Chirenje MZ, Parkin DM. AIDS and cancer in Africa: The evolving epidemic in Zimbabwe. *AIDS.* 1999; 13(18): 2583-8.

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McFarland W, Gwanzura L, Bassett MT, Machekano R, Latif AS, Ley C, Parsonnet J, Burke RL, Katzenstein D. Prevalence and incidence of herpes simplex virus type 2 infections among male Zimbabwean factory workers. *J Inf Dis.* 1999; 180(5):1459-65.

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Bassett MT, Levy L, Chokunonga E, Mauchaza B, Ferlay J, Parkin DM. Cancer in the European population of Harare, Zimbabwe, 1990-92. *Int J Cancer.* 1995; 63(1):24-2.

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Commentaries, peer-reviewed journals

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Bassett MT. Diabetes is epidemic. *Am J Public Health.* 2005; 95(9):1456.

Bassett MT, Perl S. Obesity: The public health challenge of our time. *Am J Public Health* 2004; 94(9):1477.

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Bassett MT, Wye GV, Huynh M, Paone D, Kunins HV. White individuals' risk of premature mortality in context. *Lancet*. 2017; 389(10077):1393.

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Book Chapter, Monographs, Reports, Working Papers

Committee on Informing the Selection of Leading Health Indicators for Healthy People 2030 (External Reviewer). Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine.

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Other Writing

Berger DK, Silver L, Bassett MT. Lipid control: Preventing cardiovascular events in patients with atherosclerotic disease or diabetes. *City Health Information* 2006; 25(5):33-40.

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"What they do not know can hurt them: How school-based reproductive health programmes can help adolescents lead healthy reproductive lives." Document prepared for ARHEP/TARSC June 2000. 47 Van Praagh Ave, Milton Park, Harare, Zimbabwe.

"Impact of peer education on HIV infection in Zimbabwe." Sexual Health Exchange 1998/4. KIT/SafAIDS). Royal Tropical Institute, POB 9500, 1090HA Amsterdam, The Netherlands.

"Zimbabwe: Social roots of AIDS." UNESCO Courier, 1994; 48: 17-19.

"Ethics in HIV/AIDS Research." Medical Research Council of Zimbabwe. Report of a Workshop held in Kadoma, Zimbabwe. July 1994.

"The Female Condom." SAfAIDS Newsletter, April 1994.

"Epidemic cholera – Burundi and Zimbabwe, 1992-1993." *Morbidity and Mortality Weekly Report* 1993; 42(21): 407-409.

Manual for training mid-level health workers in community health and epidemiology. Prepared on request for the Ministry for Health, Zimbabwe, 1987. Revised for second printing, 1992.

Media (selected)

Bassett, MT. "How Does Racism Affect Your Health?" *TED Radio Hour.* 13 December 2019.

Bassett MT. "How Genetics Is Changing Our Understanding of 'Race,'" Letter to the Editor, *New York Times*, April 2, 2018.

Bassett MT. In Honor of Lucy, Betsey, and Anarcha: How the Planned Removal of the Dr. J. Marion Sims Statue Honors the Women He Enslaved. *Shondaland*. Feb. 7, 2018.

Bassett MT. Americans Deserve to Know: Congress Must Resume Funding for Gun Violence Research. *Huffington Post.* Nov. 8, 2017.

Bassett MT, Morita J, Ferrer B. President Trump's Says He Wants to Stop the Opioid Crisis. His Actions Don't Match. *Time*. Nov. 2, 2017.

Bassett MT. "One in nine men have oral HPV, but we can fix this." *CNN Opinion.* Oct. 19, 2017.

Bassett MT. "Strengthening the City's Sexual Health Clinics." *Gay City News*. February 10, 2017.

Bassett M. "Health Department Engages in Internal reform to Advance Health Equity." Opinion piece. *New York Daily News*. January 16, 2017.

Bassett MT. "#WhatADoctorLooksLike – How racism and implicit bias affect health care." Opinion piece. *Essence*. October 19, 2016.

Bassett M. "Why Congress drags its feet on Zika." Opinion piece. *New York Daily News*. September 21, 2016.

Bassett MT. "New York City Offers a Model for Mental-Health Treatment," Opinion piece, *Time Magazine*, May 31, 2016.

Bassett M. "How the $15 Minimum Wage May Save Lives," Opinion piece, *New York Daily News*, April 15, 2016.

Bassett M. "Texas Abortion Case," Letter to the Editor, *New York Times*, February 26, 2016.

Bassett M. "Why We're Taking Big Moves to Curb Salt Intake: With Health Risks this Serious, People Need Better Information to Decide What to Eat," Opinion piece, *New York Daily News*, September 10, 2015.

Bassett M. "Low-fat Milk and Obesity in Kids," Letter to the Editor, *New York Times*, February 18, 2006.

Bassett MT. "Race: A Word, an Ideology or a Fact?" Letter to the Editor, *New York Times*, March 20, 2005.

Bassett MT. "Smoking isn't fashionable," Letter to the Editor, *New York Times*, October 11, 2004.

Bassett M. "Cancer: Finding it and Treating it," Letter to the Editor, *New York Times*, October 20, 2002.

Profiles (selected)

"New York City Health Commissioner Dr. Mary Bassett on Making Public Health a Social Justice." NY1. One-on-1. January 30, 2017. (By Budd Mishkin.)

"Trailblazer for Health in New York City. Perspective Profile: Mary Bassett." Lancet 2016: 387(1): 219. (By Sarah Boseley).

"A Champion of Health Equity at the Helm at the NYC Department of Health. Alumni Profile: Mary T. Bassett '79." Columbia Medicine. Columbia University. College of Physicians and Surgeons. Fall/Winter 2015. (By Rick Owens).

"In New York, Bringing a Comforting Message During a Chaotic Time: NYC Health Commissioner Has Helped Quell Ebola Fear." The New York Times. October 24, 2014. (By Michael M. Grynbaum).

Invited and Honorary Lectures (selected)

"Social Justice and Epidemiology: How Equity Advances Excellence." *Massachusetts Department of Public Health.* Boston, Massachusetts. December 16th, 2019.

"Foundations of Global Health and Population." Harvard Chan Department of Global Health and Population. Boston, Massachusetts. December 9th, 2019.

"Breaking Bondage: The Intersection of Race and Public Health." *Vital Talks.* New York, New York. November 25th, 2019.

2019 Elisabeth B. Weintz Humanitarian Award. Harvard Humanitarian Initiative. Boston, Massachusetts. November 21st, 2019.

"Critical Thinking Series." *Harvard T.H. Chan School of Public Health.* Boston, Massachusetts. November 18th, 2019.

Stephen Smith Award Ceremony. New York Academy of Medicine. New York, New York. November 7th, 2019.

Global Health Night. McGill University. Montreal, Quebec. November 5th, 2019.

"Global Health and Health Equity Session" APHA Student Assembly. Philadelphia, Pennsylvania. November 2nd, 2019.

"400 Years of Inequality." Harvard T.H. Chan School of Public Health. Boston, Massachusetts: October 28th, 2019.

"Not Just Personal: Why Understanding Structural Racism Matters."
American Society for Bioethics and Humanities Plenary Talk. The Hastings Foundation Pittsburgh, PA. October 28th, 2019.

"The Color of Healthcare: Mary Travis Bassett and Harriet Washington in Conversation." Brooklyn Historical Society. New York, NY. October 17th, 2019.

"Social Justice and Racial Equity at the Center: NYC Health Department (2014-18)" Truth and Transformation. Initiative for Institutional Anti-Racism and Accountability at the Shorenstein Center on Media, Politics and Public Policy. Cambridge, Massachusetts. October 16th, 2019.

"Law and the Nation's Health." Georgetown Law Journal. Washington, DC: October 15th, 2019.

Stigma and Access to Treatment: Harvard University and University of Michigan Summit on the Opioid Crisis. Harvard University Office of the President/François-Xavier Bagnoud Center for Health and Human Rights at Harvard University/Harvard T.H. Chan School of Public Health Office of the Dean. Boston, Massachusetts: October 10th, 2019.

"Unnatural and Unfair: How Clinicians Challenge Health Inequities." The 16th Annual Melvin H. Chalfen, MD Lecture on Public Health. Cambridge Health Alliance. Cambridge, Massachusetts. October 2nd, 2019.

Public Health Hall of Fame Award. Public Health Solutions. New York, New York: June 18th, 2019.

"Aligning Our Mission, Defining Our Future." Why Health Equity Matters: Brigham and Women's Hospital. Boston, Massachusetts. May 29th, 2019.

SUNY Downstate Medical Center Commencement. SUNY Downstate. New York, New York: May 22nd, 2019.

Yale School of Public Health Commencement. Yale School of Public Health. New Haven, Connecticut: May 20th, 2019.

Opioids: Policy to Practice – A University of Michigan – Harvard University Summit. FXB Center for Health and Human Rights at Harvard University. Boston, Massachusetts: May 10th, 2019.

"An Unbroken Thread: The Pursuit of Health, Equity, and Racial Justice." 2019 Hubie Jones Lecture in Urban Health. Boston University's Center for Innovation in Social Work and Health. Boston, Massachusetts: May 1st, 2019.

"Neglected Voices: The Global Roma Diaspora." FXB Center for Health and Human Rights at Harvard University. Cambridge, Massachusetts: April 5th, 2019.

"No Health = No Justice." Legal Action Center. New York, New York: April 3rd, 2019.

"Life and Death in Rikers Island." Vera Institute of Justice. New York, NY. March 11th, 2019.

"Reflections on Social Epidemiology: Numbers Count, History Counts More". 10th Annual Social Epidemiology Grand Rounds, Johns Hopkins Bloomberg School of Public Health. February 22, 2019.

"W.E.B. Du Bois As a Public Health Thinker" Cambridge Health Alliance, Cambridge, Massachusetts. February 15th, 2019.

"Action Beyond the Health Sector – Addressing the Social Determinants of NCDs" *Panel Discussion,* Prince Madihol Award Conference, Bangkok, Thailand. February 1st, 2019.

"Cities and Geography of Inequality." 15th International Conference on Urban Health. International Society for Urban Health, Kampala, Uganda: Nov. 28, 2018

"Can We Overcome Inequalities in Health: Experiences from New York City and USA." 2018 Future Health City Seoul Symposium. Seoul Health Foundation, Seoul, South Korea: Oct. 26, 2018.

"Uprooting Racism as Public Health Practice." Robert Wood Johnson Foundation Presidential Speaking Series. Princeton, NJ: Feb. 6, 2018.

"Discrimination: A Public Health Threat" – A Conversation. City University of New York Law Center. Queens, New York: Sept 12, 2017.

"Bending the Arc of the Moral Universe: Doing Good by Making Systems Better." Medecins Sans Frontieres-USA General Assembly: Plenary on Race, Inclusion, and Movements. New York, New York: June 23, 2017.

"Structural Racism and Health: From Evidence to Action." The Lancet: Inequality and Health in the United States: A Social Justice Symposium. Harvard Medical School. Boston, Massachusetts: April 24, 2017

"Success Stories and the Path Forward in Tobacco Prevention and Control: New York City." Closing Plenary. National Conference on Tobacco or Health. Austin, Texas: March 24, 2017.

"Epidemiology and Equity: Using Data to Advance Justice." Alexander D. Langmuir Honorary Lecture, American Epidemiological Society 90th Annual Meeting. New York, New York: March 23, 2017

"Social Work, Health Equity and Racial Justice." Sapientia et Doctrina Lecture. Fordham University Graduate School of Social Service, New York, New York; November 17, 2016.

"Advancing Health Equity as a Robert Wood Johnson Foundation Clinical Scholar." Annie Lea Schuster Alumni Speaker. Robert Wood Johnson Foundation Clinical Scholar Summit, Atlanta, Georgia; November 16, 2016.

"Public Health Meets the Problem of the Color Line." Frank A. Calderone Prize in Public Health Lecture, New York, New York; Oct. 25, 2016.

"From Bedside Manner to Sidewalk Manner." Commencement Address. Boston University School of Medicine, Boston, Massachusetts; May 12, 2016.

"The Role of Public Health Data in Advancing Health Equity in All Policies." America Public Health Association Conference, Chicago, Illinois; November 2015.

"#BlackLivesMatter: A Challenge to the Medical and Public Health Communities." Harvard T.H. Chan School of Public Health, Cambridge, Massachusetts; October 2015.

"#BlackLivesMatter: A Challenge to the Medical and Public Health Communities." David Sanders Lecture in Public Health and Social Justice. University of the Western Cape. Bellville, South Africa; July 8, 2015.

"Calories, Fat and Salt: How New York City Helped Redefine Modern Food Safety." University of the Western Cape, Bellville, South Africa; July 2015.

"Public Health as Social Justice: Addressing Health Inequities in New York City." Council of State and Territorial Epidemiologists Conference, Boston, Massachusetts; June 2015.

"Bringing a Public Health Lens to Healthcare Delivery." John Lindenbaum Memorial Lecture. Columbia University Medical Center, New York, New York; April 15, 2015.

"Public Health as Social Justice: Lessons from Harlem to Harare." Stephen Stewart Gloyd Endowed Lecture. University of Washington, Seattle, Washington; April 3, 2015.

Commencement address. New York University College of Global Public Health. New York, New York; May 14, 2012.

"Health Policy and Research in Africa: How Research in a Small Developing Country Proved Relevant to Public Health Practice in New York City." Plenary presentation. Fogarty Fellows. National Institutes of Health, Bethesda, Maryland; July 20, 2010.

"The Implementation Gap." Panel Discussion. Consortium of Universities for Global Health, Seattle, Washington; 2010.

"New York City's Lifestyle Health: Obesity, The Environment, Policy & Programs." YMCA Community Forum on Lifestyle Health, New York, New York; September 11, 2008.

"Using Local Government Authority to Meet the Challenge of Obesity: The New York City Experience." CDC National Summit on Legal Preparedness for Obesity Prevention and Control, Atlanta, Georgia; June 18, 2008.

"Tackling Health Inequalities in New York City: Top Down or Bottom Up?" MacArthur Foundation, Research on Socioeconomic Status and Health Network, New York, New York; September 27, 2007.

"Creating a Healthy Environment: The Trans Fat Ban in New York City." 84th Annual Conference New York State Association for Food Protection, Syracuse, New York; September 20, 2007.

"Tobacco Control in New York City." Flight Attendant Medical Research Institute. Johns Hopkins School of Public Health, Baltimore, Maryland; January 29, 2007.

"New York City Approaches to Colon Cancer." National Colorectal Cancer Round Table, Washington, District of Columbia; December 6, 2006.

"Implementing Multilevel Interventions: Challenges for Health Department." 2nd International Conference on Urban Health. New York Academy of Medicine, New York, New York; October 18, 2003.

"Voluntary Counseling and Testing: Optimizing the impact." Plenary presentation. Third annual meeting. Global Strategies for Prevention of HIV transmission from Mother to Infant, Kampala Uganda; September 9, 2001.

Debate: "Does Structural Adjustment fuel the AIDS epidemic?" XIIIth International Conference on HIV/AIDS, Durban, South Africa; July 2000.

"Impact of Structural Adjustment on Urban and Rural Households in Zimbabwe." Plenary presentation. Epidemiology Association of Southern Africa (ESSA), East London, South Africa; February 2000.

"Psychosocial and Community Perspectives on Alternatives to Breastfeeding." Plenary presentation. Global Strategies for Prevention of HIV transmission from Mother to Infant, Montreal, Canada; September 3, 1999.

"User and Community Perspectives of Microbicide/Spermicides." Plenary presentation. Proceedings of the 10th World Congress on Human Reproduction, Salvador, Brazil; May 4-8, 1999 Edited by Coutinho E.M. and Spinola P. Department of Gynecology, Obstetrics and Human Reproduction. Faculty of Medicine, Federal University of Bahia, Brazil.

"Public Health Crisis in Africa: AIDS and Economic Reform." Plenary presentation. Health and Society in African. Berkeley-Stanford (California) Joint Center; April 24, 1999.

"Strategies for Preserving Breast Feeding." Social Science Track D Plenary, XIIth International Conference on AIDS, Geneva, Switzerland: June 30, 1998.

"Enabling strategies in HIV prevention: Experience from Zimbabwe." Global Program on AIDS. World Health Organization, Geneva, Switzerland; September 1993.

"Social and Economic Determinants of Vulnerability to HIV Infection." Plenary presentation. VIIIth International Conference on AIDS, Berlin, Germany; June 7-11, 1993.

"Women and AIDS in Zimbabwe." Institute for History of Science, Massachusetts Institute of Technology, Cambridge, Massachusetts; April 1990.

"AIDS in Africa: Epidemiology and Social Dimensions." Lecture series on "AIDS: Biological and Social Dimensions." Massachusetts Institute of Technology, Cambridge, Massachusetts; October 1989.

"Evaluating asbestos-related research in Africa." Occupational Safety and Health, Ministry of Labour and Asbestos Institute, Montreal, Canada; August 1987.

Hosted Lectures (selected)

"Are Epidemiologists Scientists or Public Health Practitioners?". Society for Epidemiologic Research. November 13th, 2019. Online.

Critical Thinking Series. Harvard Chan School Department of Global Health and Population. Location: Boston, Massachusetts. November 18th, 2019.

"Making It Practical: The Pursuit of Equity in Public Health." Ounce of Prevention. Massachusetts Department of Public Health. Boston, Massachusetts; April 2nd, 2019.

"Invisible Hands Film Screening." FXB Center for Health and Human Rights at Harvard University. Boston, Massachusetts; March 28th, 2019.

"Empowering Transgender Youth, their Families and Communities: Lessons Learned the Gender & Family Project," Jean Malpas, LMHC, LMFT, Ackerman Institute for the Family. Queens: New York; July 30, 2018.

"In Plain Sight: Race, Racism and Colorblindness," Alvin Starks, Senior Program Officer, Open Society Foundations. Queens: New York; July 16, 2018.

"Reflections on Resiliency," Dr. Oxiris Barbot, First Deputy Commissioner, and the DOHMH Mental Health Response Team. Queens: New York; May 1, 2018.

"Maryland's Health Enterprise Zones: A Model for Addressing Social Determinants of Health," Michelle Spencer, Johns Hopkins University. Queens: New York; April 24, 2018.

"Working Toward Recovery: U.S. Virgin Islands," DOHMH U.S. Virgin Islands Recovery Team. Queens: New York; March 7, 2018.

"Insecurity and Energy Justice: A Call for Public Health," Dr. Diana Hernández, Assistant Professor of Sociomedical Sciences at Columbia University's Mailman School of Public Health. Queens: New York; March 5, 2018.

"Characterizing and Measuring Racism: Implications for Addressing Racial Inequities in Health," Dr. Courtney Cogburn, Assistant Professor, Columbia School of Social Work. Queens: New York; January 29, 2018.

"After Hurricane Maria: A Discussion on DOHMH's Relief Effort," Oxiris Barbot, MD, First Deputy Commissioner, New York City Department of Health and Mental Hygiene. Queens: New York; December 20, 2017.

"Health and Racist Ideas: A History," Ibram X. Kendi, PhD, Professor of History and International Service, American University and Director of the Anti-Racist Research and Policy Center at American University. Queens: New York; December 5, 2017.

"Leveling the Playing Field: Achieving Equity and Eliminating Racial/Ethnic Disparities in Children's Health and Healthcare," Glenn Flores, MD, FAAP, Chief Research Officer and

Director of the Health Services Research Institute, Connecticut Children's Medical Center. Queens: New York; November 29, 2017.

"Building Health," Stephen Yablon, AIA, LEED AP, Stephen Yablon Architecture. Queens: New York; October 30, 2017.

"Overview of Contemporary Issues in Global Public Health Law and Responses to Global Public Health Crises," Lawrence O. Gostin, JD, University Professor, Georgetown University Law Center; Founding O'Neill Chair in Global Health Law; Faculty Director, O'Neill Institute for National and Global Health Law, and Director, World Health Organization Collaborating Center on National & Global Health Law. Queens: New York; September 26, 2017.

"How We Created a Public Health Crisis by Segregating our Neighborhoods," Richard Rothstein, Research Associate, Economic Policy Institute; Senior Fellow, Chief Justice Earl Warren Institution on Law and Social Policy, and University of California, Berkeley School of Law. Queens: New York; September 14, 2017.

"Latino Immigrants, Acculturation and Health: Promising New Directions in Research," Ana Abraído-Lanza, PhD, Professor, Department of Sociomedical Sciences; Program Director, Initiative for Maximizing Student Development, and Mailman School of Public Health, Columbia University. Queens: New York; July 17, 2017.

"Dismantling Structural Racism: Strategies for Public Health Practitioners," Zinzi Bailey, ScD, MSPH, Director of Research and Evaluation, Center for Health Equity, NYC Department of Health and Mental Hygiene. Queens: New York; June 20, 2017.

"The State of Black Immigrants," Carl Lipscombe, Deputy Director, Black Alliance for Just Immigration, and Co-Founder of #BlackLivesMatter. Queens: New York; May 8, 2017.

"Labor of Love: Transforming the Way We Care." Ai-jen Poo, Executive Director of the National Domestic Workers Alliance and Co-Director of Caring Across Generations. Queens, New York; April 17, 2017.

"Race, Place and Chronic Disease: Segregation as a Root Determinant of Health Inequities," Brian Smedley, Ph.D., Co-Founder and Executive Director, National Collaborative for Health Equity. Queens, New York; March 1, 2017.

"Screening RIKERS & Discussing Mass Incarceration with Just Leadership USA," Khalil A. Cumberbatch, Manager of Trainings, JustLeadershipUSA, and Janos Marton, Director of Policy and Campaigns, JustLeadershipUSA. (JustLeadershipUSA is dedicated to cutting the U.S. correctional population in half by 2030.) Queens, New York; February 22, 2017.

"Drug Policy, Black Life and History: Notes toward a Harm Reduction of Color Critique," Samuel Kelton Roberts, Jr., PhD, Director, Columbia University Institute for Research in African-American Studies; Associate Professor of History, Columbia University School of Arts and Sciences, and Associate Professor of Sociomedical Sciences, Columbia University, Mailman School of Public Health. Queens, New York; January 30, 2017.

"Violence Against Transgender Individuals and Communities as a Public Health Crisis," LaLa Zannell, Lead Organizer, New York City Anti-Violence Project; Elana Redfield, Director, LGBTQI Affairs, New York City Human Resources Administration, and Olympia Perez, TransJustice Program Co-Coordinator for Leadership Development, Audre Lorde Project. Queens, New York; November 21, 2016.

"Medical Apartheid in Hospitals in New York City," Neil S. Calman, MD, FAAFP, President and Chief Executive Officer, Institute for Family Health, and Chair, Department of Family Medicine and Community Health, Icahn School of Medicine, Mount Sinai. Queens, New York; July 20, 2016.

"Shifting Social Climates and the Health of Sexual Minorities in the United States," Ilan Meyer, PhD, Williams Senior Scholar of Public Policy, Williams Institute, University of California, Los Angeles, School of Law. Queens, New York; June 6, 2016.

"The Politics of Premature Death in Black America," Khalil Gibran Muhammad, PhD, Director, Schomburg Center for Research in Black Culture, New York Public Library. Queens, New York; May 4, 2016.

"The Health of Latino Populations: Key Questions and Issues," Ana Abraido-Lanza, PhD, Associate Professor, Sociomedical Sciences, Columbia University, Mailman School of Public Health. Queens, New York; April 12, 2016.

"Pursuing Equality for Mental Health: Lessons from the United Kingdom," Right Honorable Norman Lamb, Member of Parliament, and Minister of State for Community and Social Care at the Department of Health in the United Kingdom Government (2012-2015). Queens, New York; April 4, 2016.

A Conversation and Musical Performance with the Kuumbra Singers of Harvard College. Queens, New York; March 14, 2016.

A Conversation with Yusef Salaam, convicted of assault and rape in 1990 as one of the Central Park Five. Queens, New York; February 28, 2016.

"From Mississippi Freedom Summer to Black Lives Matter: Recollections on Race, Health and the Civil Rights Movement," Robert Fullilove, EdD, Professor and Associate Dean, Community and

Minority Affairs, Sociomedical Sciences, Columbia University Medical Center. Queens, New York; February 24, 2016.

"The Protest Psychosis: How Schizophrenia Became a Black Disease," Jonathan Metzl, MD, PhD, Director of the Center for Medicine, Health and Society, and Professor of Psychiatry, Vanderbilt University. Queens, New York; January 25, 2016.

"Mistreating Health Inequities: Race, Medicine and Justice," Dorothy E. Roberts, JD, Professor of Law, University of Pennsylvania. Queens, New York; October 2, 2015.

"Avertable Deaths: The Power and Limitations of the Message," Dr. Steven Woolf, MD, MPH, Director of the Virginia Commonwealth University Center on Society and Health, and Professor of Family Medicine and Population Health, Virginia Commonwealth University. Queens, New York; June 26, 2015.

"Body and Soul: The Black Panther Party and the Fight Against Medical Discrimination," Alondra Nelson, PhD, Dean of Social Science, Professor of Sociology and Gender Studies, Columbia University. Queens, New York; June 22, 2015.

"Community Loss and Neighborhood Risks: New Social Indicators," Mimi Abramovitz, DSW, Bertha Capen Reynolds Professor of Social Policy, and Chair, Social Policy Curriculum Area, Silberman School of Social Work at Hunter College, City University of New York; City University of New York Graduate Center. Queens, New York; May 4, 2015.

"Taking Population Health Seriously: Implications for Research and Practice," Ana V. Diez Roux, MD, PhD, MPH, Dean, Drexel University School of Public Health. Queens, New York; April 1, 2015.

"Re-framing Women's Health with a Reproductive Justice Lens," Lynn Roberts, Assistant Professor, Community Health, City University of New York School of Public Health. Queens, New York; March 16, 2015.

Black History Month film "Changing Face of Harlem" introduction, Chirlane McCray, First Lady of New York City. Queens, New York; February 17, 2015.

A Conversation with Victor Dzau, MD, President, National Academy of Medicine, and Community Health Leaders. Attendees included representation from area hospitals and universities, local and national funders, community-based organization such as Makes the Road New York and the New York City Justice Alliances and other key stakeholders. Queens, New York; Jan. 13, 2015.

"The Housing and Neighborhood Study: Research Design and Preliminary Findings," Elyzabeth Gaumer, Acting Assistant Commissioner, Research & Evaluation, New York City Department of Housing Preservation and Development. Queens, New York; January 12, 2015.

"Neighborhoods, Housing and Health: A Panel Discussion with Emerging Researchers," Dustin T. Duncan, ScD, Assistant Professor, Department of Population Health, New York University School of Medicine, and Mariana C. Arcaya, ScD, Yerby Postdoctoral Research Fellow, Harvard University Center for Population and Development Studies. Queens, New York; December 8, 2014.

"Fair Society, Healthy Lives: Getting Evidence into Action," Sir Michael Marmot, Professor of Epidemiology and Public Health, and Director, Institute for Health Equity, University College London. Queens, New York; November 5, 2014.

"Health As Equity Actualized: Real Life Communications Approaches to Addressing Root Causes," Makani Themba, Executive Director, Praxis Project. Queens, New York; October 14, 2014.

"Racial Equity at the Intersection of Public Health and Health Care: Lessons Learned through the W.K. Kellogg Foundation America Healing Racial Equity Initiative," Gail Christopher, DN, Vice President for Program Strategy, W.K. Kellogg Foundation. Queens, New York; June 23, 2014.

"Making the Case for Equity: Advancing Health Equity Through Place-Based Solutions," Angela Glover Blackwell, Founder and Chief Executive Officer, PolicyLink; and Mildred Thompson, Director, PolicyLink, Center for Health Equity and Place. Queens, New York; May 19, 2014.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, *et al*., Plaintiffs, v. GREG ABBOTT, in his official capacity as Governor of Texas, *et al*., Defendants.	No. 1:20-cv-00323-LY

DECLARATION OF STEPHANIE CHANG, M.D.

Stephanie Chang, M.D., declares as follows:

1. I am a board-certified obstetrician and gynecologist ("OB/GYN"), and a medical doctor licensed in the State of Texas and in good standing with the Texas Medical Board. My clinical practice includes both obstetrics and gynecology.

2. I graduated from UT Southwestern Medical School in 2007, completed a residency in obstetrics and gynecology at UT Southwestern Medical Center in 2011, and thereafter joined the faculty at UT Southwestern Medical Center as a member of the Department of Obstetrics and Gynecology. My primary site of practice is at Parkland Memorial Hospital.

3. I am a fellow/member of the American College of Obstetricians and Gynecologists ("ACOG"), the American Association of Gynecologic Laparoscopists, and the Association of Professors of Gynecology and Obstetrics. I am also a member of Parkland Memorial Hospital's Medical Executive Committee.

4. I make this declaration based upon my personal knowledge and am competent to testify thereto.

5. The statements in this declaration are attributable solely to me; I do not speak on behalf of any institution or organization with which I am affiliated.

6. Based on my practice, I am familiar with the use of personal protective equipment ("PPE") during obstetrical and gynecologic care, including prenatal care, labor and delivery, abortion, and other essential procedures, as well as non-essential procedures.

7. As a physician, I understand well the impact COVID-19 will have on patients and the health care systems. Like other members of the medical community, I do my part to conserve needed PPE and preserve hospital resources for potential COVID-19 patients. However, this does not mean turning away patients in need of time-sensitive care.

8. Throughout pregnancy, regular visits with an OB/GYN are strongly recommended.[1] These prenatal care visits are essential to ensuring the health of the mother and fetus. For these reasons, prenatal care visits are continuing during the COVID-19 outbreak.

9. During prenatal care visits, OB/GYNs perform diagnostic tests (such as ultrasounds, blood tests, and genetic testing) and physical exams (such as blood pressure tests and pelvic exams) to, for example, ensure fetal growth and check for any complications, not just for the fetus, but also for the pregnant patient.

10. The American Academy of Pediatrics and ACOG, as well as the federal government,[2] recommend that for uncomplicated first pregnancies, the patient visit their OB/GYN

[1] Am. Acad. of Pediatrics & ACOG, Guidelines for Perinatal Care 149 (8th ed. 2017).

[2] Office on Women's Health in the U.S. Dep't of Health & Human Servs., *Prenatal Care and Tests* (last updated Jan. 30, 2019), https://www.womenshealth.gov/pregnancy/youre-pregnant-now-what/prenatal-care-and-tests.

every four weeks during the first and second trimesters (to twenty-eight weeks), every two weeks until thirty-six weeks, and every week from thirty-six weeks to delivery. Thus, for a patient who initiates prenatal care at eight weeks of pregnancy (which is the recommended timing of the first visit), the patient will have approximately fourteen visits with their OB/GYN, including delivery. Patients with risk factors for complications (such as multiple pregnancies, pre-existing medical conditions such as high blood pressure, or advanced age) require more visits.[3] A majority of Texas women seek prenatal care during the first trimester, according to the most recent data from the Texas Department of State Health Services.[4]

11. During the COVID-19 pandemic, ACOG recommends that "[a]ntenatal fetal surveillance and ultrasonography . . . should continue as medically indicated when possible."[5] ACOG acknowledges the crisis may warrant delaying some prenatal care only "if the risk of exposure and infection within the community outweighs the benefit of [prenatal] testing" and ultrasonography. In places where there is a high risk of inadvertent exposure, ACOG suggests a reduced or modified schedule (no less than five in-person visits) may be appropriate, but normal care schedules should resume when the risk subsides.[6]

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[3] Risk factors for pregnancy complications are relatively common. For example, in 2018, 28% of pregnant women in Texas fell in the obese range of the pre-pregnancy Body Mass Index, a risk factor for developing hypertension, diabetes, and a variety of other medical problems during pregnancy. Tex. Dep't of State Health Servs., *2019 Texas Healthy Mothers & Babies Data Book* at 42–45 & Fig. 30 (revised Feb. 6, 2020), *available at* https://www.dshs.Texas.gov/healthytexasbabies/Documents/HTMB-Data-Book-2019-20200206.pdf.

[4] Tex. Dep't of State Health Servs., *Onset of Prenatal Care Within the First Trimester*, (last updated Apr. 12, 2019), https://www.dshs.texas.gov/chs/vstat/vs15/t12.asp.

[5] ACOG, *COVID-19 FAQs for Obstetrician-Gynecologists, Obstetrics* (last updated Mar. 26, 2020), https://www.acog.org/clinical-information/physician-faqs/covid-19-faqs-for-ob-gyns-obstetrics.

[6] ACOG, *Examples of Alternate or Reduced Prenatal Care Schedules* (Mar. 24, 2020), https://www.acog.org/clinical-information/physician-faqs/-/media/287cefdb936e4cda99a683d3cd56dca1.ashx.

12. Prenatal visits to conduct diagnostic tests necessarily must be in person, and as a result, require the use of PPE. The initial prenatal care visit requires a physical exam (including a pelvic examination and sometimes a pap smear), blood testing, urine tests, STD screening, and an ultrasound if needed to confirm the gestational age of the pregnancy.

13. Throughout prenatal care visits, patients are provided several genetic tests. Cell-free DNA testing, which is done to screen for various genetic conditions or aneuploidy, is done during the initial or an early prenatal visit. Two additional genetic tests requiring blood draws, including quadruple-marker screening test (which measures the levels of four different hormones in the patient's blood), are done between eleven and twenty-two weeks. If a patient needs a chorionic villus sampling (which analyzes a biopsy from the placenta), that is usually provided between ten and thirteen weeks, and amniocentesis (which analyzes fetal cells in a sample of amniotic fluid taken from the gestational sac) is done beginning at approximately fifteen weeks. Both procedures involve the insertion of a needle into the uterus, which can be painful, and both procedures carry the risk of complications, such as infection, miscarriage, and preterm labor.[7]

14. Some patients with risk factors for complications, including patients over thirty-five years of age, may need additional genetic testing.

15. Gloves are used when conducting an ultrasound, obtaining fetal heart tones, drawing blood, or collecting specimens. If a pelvic exam is needed, both the OB/GYN and a nurse-chaperone wear gloves.

[7] Johns Hopkins Med., Chorionic Villus Sampling (CVS), https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/chorionic-villus-sampling-cvs (last visited Apr. 1, 2020); Johns Hopkins Med., Amniocentesis, https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/amniocentesis (last visited Apr. 1, 2020).

16. Nearly all births in Texas occur in a hospital,[8] and approximately one-third of deliveries are by cesarean section ("C-section"), an open abdominal surgery requiring hospitalization for at least a few days.[9] During a vaginal delivery, the nurse, the OB/GYN, and between one to four pediatricians or pediatric nurse practitioners, depending on the status of the infant, are present. The delivering provider wears a surgical mask with face shield and a surgical gown. Each pediatric clinician wears a surgical mask and a disposable contact isolation gown. Everyone wears non-sterile gloves, except for the delivering provider, who wears sterile gloves.

17. C-sections require more hospital staff and thus comparatively more PPE use. For a C-section, two OB/GYN surgeons, an operating room technician, a circulating nurse, one to two anesthesia providers, and at least one pediatric provider are needed. If the mother or newborn needs to be intubated, even more staff is required.

18. In light of the governor's Executive Order and the risks to pregnant patients from obtaining care at the hospital, all scheduled procedures (i.e., elective procedures[10]) are performed in the outpatient setting—either at an office visit or ambulatory surgical center. Hospital-based care is reserved for emergent and urgent cases, as well as all deliveries. At the hospital, each patient

[8] Tex. Dep't of State Health Servs., *Summary of Vital Statistics for Texas 2014* (last updated Apr. 1, 2019), https://www.dshs.texas.gov/chs/vstat/vs14/nsumm.aspx ("In 2014, 98.5 percent of Texas resident births were delivered in a hospital.").

[9] *Id.*; Am.'s Health Rankings, United Health Found., *Low-Risk Cesarean Delivery in Texas*, https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/low_risk_cesarean/state/TX (last visited Apr. 1, 2020).

[10] As the American Hospital Association has recognized, "'elective' simply means a procedure is scheduled rather than a response to an emergency." Am. Hosp. Ass'n et al., *AHA Letter to Surgeon General Re: Elective Surgeries and COVID-19* (Mar. 15, 2020), https://www.aha.org/lettercomment/2020-03-15-aha-letter-surgeon-general-re-elective-surgeries-and-covid-19. Johns Hopkins Med., *Types of Surgery*, https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/types-of-surgery ("An elective surgery does not always mean it is optional. It simply means that the surgery can be scheduled in advance.") (last visited Apr. 1, 2020).

is allowed one support person in the labor and delivery unit and in the postpartum unit. No visitors or support people are allowed in for prenatal visits or antepartum admissions.

19. Most gynecologic care is medically indicated,[11] and thus the decision whether to postpone care is made after weighing other factors, including the risk to the patient.

20. I understand the Executive Order directs individual physicians to determine whether it is safe to postpone their patients' care. I also understand the Executive Order does not apply "to any procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster."

21. Similarly, CMS,[12] the American College of Surgeons,[13] ACOG,[14] and other professional medical organizations recommend that the decision to postpone non-urgent cases should be weighed against current and projected COVID-19 cases, PPE supply, and other factors.

22. At present, hospital policies to preserve PPE have been put in place so that adequate PPE supplies are maintained to manage current patients with urgent or medically-indicated need while also preserving supplies for a potential COVID-19 surge. Thus, time-sensitive procedures required to correct gynecologic conditions or to evaluate for or treat malignancy are still being provided. These procedures include but are not limited to loop electrosurgical excision procedures

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[11] Am. Coll. of Surgeons, *COVID-19 Guidelines for Triage of Gynecology Patients* (Mar. 24, 2020), https://www.facs.org/covid-19/clinical-guidance/elective-case/gynecology; ACOG et al,, *Joint Statement on Elective Surgeries* (Mar. 16, 2020), https://www.acog.org/clinical-information/physician-faqs/~/link.aspx?_id=CBA52761BB3B4A6EA5D07729597C0609&_z=z.

[12] Sameer Siddiqui, *CMS Adult Elective Surgery and Procedures Recommendations*, Ctrs. for Medicare & Medicaid Servs., (Mar. 15, 2020), https://www.cms.gov/files/document/31820 - cms-adult-elective-surgery-and-procedures-recommendations.pdf.

[13] Am. Coll. of Surgeons, *COVID-19: Guidance for Triage of Non-Emergent Surgical Procedures* (Mar. 17, 2020), https://www.facs.org/covid-19/clinical-guidance/triage; Am. Coll. of Surgeons, *COVID-19 Guidelines for Triage of Gynecology Patients*, *supra* note 11.

[14] ACOG et al., *supra* note 11.

("LEEPs"), colposcopies, hysteroscopies, and cervical dilation with curettage (to manage miscarriage, or for evaluation of abnormal bleeding or intracavitary uterine masses).[15] LEEPs are procedures used to remove abnormal cells that may cause cervical cancer. Colposcopies are diagnostic procedures used to detect abnormal cells in the cervix and vagina. Hysteroscopy is a procedure to view the inside of the cervix and uterus for any abnormalities and if necessary remove abnormal tissue.

23. These procedures use minimal PPE: sterile gloves, a surgical gown, and a surgical mask. Given the conservation measures put in place, performing these outpatient procedures does not currently deplete hospital capacity or the PPE that is needed to cope with the COVID-19 pandemic.

24. The PPE used for procedural abortion is not greater than that used for currently allowable procedures. It is similar to that needed for prenatal care visits for patients at the same gestational ages, and most certainly less if one includes unplanned ER visits, labor, and delivery for a pregnancy that is carried to term. As with other outpatient procedures, practitioners providing procedural abortions may wear some or all of the following items: gloves, a surgical mask, and reusable scrubs.

25. The pandemic does not require use of N95 respirators for all procedures. Instead, an N95 mask is used if the patient has COVID-19 risk factors, symptoms, or a known exposure. Consistent with CDC guidance (and the guidance of medical professional organizations),[16] if a face mask is needed, a surgical face mask is adequate, and therefore, I use a surgical mask for all

[15] However, tubal ligations (other than after a C-section) and insertions of intrauterine devices and contraceptive implants are postponed.

[16] Am. Coll. of Surgeons, *COVID-19: Elective Case Triage Guidelines for Surgical Care* (Mar. 24, 2020), https://www.facs.org/covid-19/clinical-guidance/elective-case.

my procedures (including deliveries), unless there is a suspicion of or confirmed case of COVID-19.[17] In fact, the CDC cautions that "[s]pecial care should be taken to ensure that respirators are reserved for situations where respiratory protection is most important, such as performance of aerosol-generating procedures on suspected or confirmed COVID-19 patients or provision of care to patients with other infections for which respiratory protection is strongly indicated (e.g., tuberculosis, measles, varicella)."[18]

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

Stephanie Chang, M.D.

Executed: April 2, 2020

[17] A recent study out of UT Southwestern, which was published in the *Journal of the American Medical Association*, found that there is "no significant difference in the effectiveness" of medical masks compared to N95 respirators for prevention of influenza or other viral respiratory illness. Lewis J. Radonovich et al., *N95 Respirators vs Medical Masks for Preventing Influenza Among Health Care Personnel: A Randomized Clinical Trial,* 322 JAMA 824, 832 (2019), *available at* https://jamanetwork.com/journals/jama/fullarticle/2749214; *see also* Mark Loeb et al., *Surgical Mask vs N95 Respirator for Preventing Influenza Among Health Care Workers: A Randomized Trial*, 302 JAMA 1865, 1870 ("Our data show that the incidence of laboratory-confirmed influenza was similar in nurses wearing the surgical mask and those wearing the N95 respirator.").

[18] Ctrs. for Disease Control and Prevention, *Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings* (last updated Apr. 1, 2020), https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html. In this context, "aerosols" refer to "respiratory droplets [that are] produced when the infected person coughs or sneezes."

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE; *et al.*,	)	
	)	CIVIL ACTION
Plaintiffs,	)	
	)	CASE NO. 1:20-cv-323-LY
v.	)	
	)	
GREG ABBOTT, in his official capacity as Governor; *et al.*,	)	
	)	
Defendants.	)	

DECLARATION OF KAMYON CONNER, M.S.W.

KAMYON CONNER, M.S.W. hereby declares under penalty of perjury that the following statements are true and correct:

1. I am the Executive Director of the North Texas Equal Access Fund ("TEA Fund"), a Dallas-based nonprofit organization that provides direct financial assistance to people who want to end a pregnancy but cannot afford abortion care in Texas.

2. I have provided services at TEA Fund for nearly fifteen years, first as a volunteer fielding calls for assistance to our hotline, known as the Helpline, from 2006 to 2013, and then as a Board Member and Intake Coordinator until 2018. In the latter roles, I helped shape the mission and strategy of the organization based on our clients' experiences, and I participated in the TEA Fund's financial and resource distribution planning .

3. In my current role as Executive Director of the TEA Fund, I oversee our Helpline; Client Engagement Program, which supports clients throughout the process of terminating a pregnancy, including in-person support during an abortion procedure; Caller Engagement Program, which organizes people throughout Texas to advocate for abortion access with dignity,

including by sharing stories of their abortion experiences; and Communications. These programs are run by six other staff members and over 125 active volunteers.

4. I provide the following testimony based on personal knowledge acquired through my service at the TEA Fund and review of the organization's business records.

Ongoing Challenges to Obtaining Abortion Care in Texas

5. In 2019, the Helpline received over 6,500 calls from people seeking help paying for an abortion. The calls came from 110 counties in Texas, many of them rural. At least 70% of the callers already had a child. Texas requires most patients to make two trips to obtain abortion care, which imposed transportation and childcare costs on many of the callers while depriving them of wages. For some, efforts to gather resources on their own had forced them to delay their appointments, which only increased the cost of their abortion care because it occurred at a later gestational age.

6. The TEA Fund allocates funds for abortions per week and only provides financial assistance for those scheduled within seven days of a call. A caller can qualify for assistance depending on their financial circumstances, the amount of financial aid they are able to obtain from other sources, and the total cost of the abortion. When a caller qualifies, the TEA Fund sends a financial voucher to the abortion provider with whom the patient's appointment is scheduled and pays the provider after the patient has received care. In 2019, the TEA Fund provided over $277,000 to assist 924 Texas residents in obtaining abortions.

7. Unfortunately, financial constraints prevent us from providing financial assistance to every caller who needs it and from covering the full cost of the abortion for the callers we can help. In 2019, we were able to provide financial assistance to about one-quarter of the people who requested it. Through our Client Engagement Program, we have observed that some callers who

receive our assistance experience an emotional strain from having to meet the remaining costs, which makes their overall abortion experience stressful.

Impact of Executive Order

8. The public health crisis precipitated by COVID-19 has exacerbated the difficulties Texans, particularly low-income people and people of color, have affording abortion care. Many of our recent callers are struggling with layoffs and furloughs, dealing with the possibility of eviction, experiencing other unforeseen medical costs, and contending with increased utility bills caused by sheltering at home.

9. I understand that Attorney General Paxton has interpreted an Executive Order by Governor Abbott concerning the public health crisis to ban most abortions. I also understand that this interpretation would eliminate most or all abortion care for my clients, which would have a devastating effect on their well-being.

10. The TEA Fund began committing funding for abortions in Texas for the current seven-day period on Thursday, March 19. The Attorney General publicized its interpretation on Monday, March 23. Between March 19 and 23, we committed funding to more than two dozen clients, many of whom will now be unable to obtain an abortion in Texas while the Executive Order remains in effect. At least four of those clients are over 18 weeks lmp. They will undoubtedly lose the ability to obtain an abortion in Texas before the Executive Order expires on April 21, 2020.

11. The inability to receive an abortion in Texas usually drives TEA Fund clients to seek that care out-of-state, including New Mexico, Colorado, and Louisiana. But long-distance travel is increasingly dangerous and difficult during the public health crisis given the toll of COVID-19 on already-limited resources and the pronounced difficulty of securing childcare

during the crisis. Moreover, my understanding from collaborating with abortion funds and providers in other states is that abortion care is presently unavailable in Louisiana. Clients who are unable to access abortion in Texas or do so in another State are forced to remain pregnant against their will, which can cause them and their families extreme anguish, and potentially forced to carry to term.

Dated: March 25, 2020

/S/ Kamyon Conner
Kamyon Conner
Executive Director
TEA Fund

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, et al., Plaintiffs, v. GREG ABBOTT, in his official capacity as Governor of Texas, et al., Defendants.	No. 1:20-cv-00323-LY

DECLARATION OF ALICIA DEWITT-DICK IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

I, ALICIA DEWITT-DICK, declare as follows:

1. I am the administrator of Plaintiff Southwestern Women's Surgery Center ("Southwestern").

2. Southwestern operates a licensed ambulatory surgical center in Dallas. Southwestern provides medication abortion up to 10 weeks as measured from the first day of the woman's last menstrual period ("LMP") and procedural abortions through 21.6 weeks LMP, as well as miscarriage management and contraceptive services. Southwestern provides care to approximately 9000 patients a year.

3. As administrator, I oversee operations at the clinic and am familiar with all aspects of our policies and practices. The facts I state here are based on my experience, my review of Southwestern's business records, information obtained in the course of my duties at Southwestern, and personal knowledge that I have acquired through my service at Southwestern.

4. I submit this declaration in support of Plaintiffs' motion for a temporary restraining order followed by a preliminary injunction, which seeks to enjoin the March 22, 2019 Executive Order No. GA-09 (the "Executive Order"), as interpreted by the Texas Attorney General on March 23, 2020 to ban all previability abortion procedures in the state except where immediately necessary to protect the life or health of a patient. I have reviewed the Executive Order and the interpretation by the Attorney General.

5. The Executive Order, effective until 11:59 p.m. on April 21, 2020, although it may be extended, directs "all licensed health care professionals and all licensed health care facilities" to "postpone all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician." *Id.* at 1. The Executive Order states that this prohibition does not apply to "any procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment ["PPE"] needed to cope with the COVID-19 disaster." *Id.*

6. Southwestern understands the term PPE to refer to surgical masks, N95 respirators (a face covering designed to block at least 95 percent of very small test particles), sterile and non-sterile gloves, disposable protective eyewear, disposable gowns, and disposable shoe covers. The services Southwestern provides do not involve significant amounts of PPE or deplete PPE.

7. On Monday, March 23, 2020, the Attorney General issued a press release interpreting the Executive Order, titled "Health Care Professionals and Facilities, Including Abortion Providers, Must Immediately Stop All Medically Unnecessary Surgeries and Procedures to Preserve Resources to Fight COVID-19 Pandemic." The press release states that the Executive

Order applies to "all surgeries and procedures that are not immediately medically necessary," including "most scheduled healthcare procedures that are not immediately medically necessary such as orthopedic surgeries or any type of abortion that is not medically necessary to preserve the life or health of the mother." The release invokes the order's application to abortion providers four times. It states that a "[f]ailure to comply with an executive order issued by the governor related to the COVID-19 disaster can result in penalties of up to $1,000 or 180 days of jail time" and warns that "[t]hose who violate the governor's order will be met with the full force of the law."

8. Southwestern is uncertain as to the scope of the Executive Order and the subsequent press release by the Attorney General, and, as a result, largely stopped seeing patients on March 23, 2020. The clinic has cancelled approximately 225 appointments for the last two days, March 24 and March 25. Unless we obtain immediate relief, we intend to continue canceling appointments going forward.

Southwestern's Response to COVID-19:

9. Approximately a month prior to the Executive Order, in late February, Southwestern began to take actions within the clinic to address the spread of COVID-19 around the country and developed practices directed at reducing the risk of transmission and preserving PPE.

10. On February 24, 2020, the clinic began screening all patients for potential exposure to COVID-19, using screening questions related to existing respiratory symptoms and recent travel. We instructed staff to stay home if they were experiencing any symptoms associated with COVID-19.

11. On March 13, 2020, we also began limiting the number of people in waiting areas to ensure social distancing of at least 6 feet between all persons, and implemented staff techniques to minimize the use of PPE, including restricting the use of new surgical masks and gowns.

12. On March 16, 2020, Southwestern began checking the temperatures of all patients upon arrival in addition to continuing to ask patients screening questions regarding their symptoms and travel. Southwestern also began requiring that patients complete admission paperwork and wait in their vehicles to be seen by the physician.

13. On March 18, 2020, we began checking temperatures of staff daily.

14. There have only been a few instances where staff have experienced potential symptoms or contact that raises a low but non-negligible possibility of infection, and we have sent the staff members home.

15. Southwestern has only canceled an appointment for one patient due to concern for a possible COVID-19 infection.

16. While we have a limited number of N95 masks at the clinic, we would only use them if we were treating a patient with a suspected or confirmed COVID-19 infection. We have not used any of these masks to date during the pandemic.

17. Southwestern has also suspended its training program for residents and fellows until the end of April and halted onboarding of new staff.

Southwestern Uses Minimal PPE:

18. In 2019, Southwestern performed 8800 abortions, including 2321 medication abortions prior to 10 weeks LMP. Of the procedural abortions, 5689 were performed at or before 14.6 weeks LMP via suction procedure. The remaining 790 were performed from 15 weeks LMP through 21.6 weeks LMP. Southwestern also performed 240 miscarriage management procedures

in 2019. The clinic does not have 2020 data available yet, but the first months of 2020 are in line with these earlier figures.

19. For consults and ultrasounds, Southwestern typically only uses one pair of non-sterile gloves per patient, but has reduced such use in light of the COVID-19 pandemic. PPE is not typically used for dispensing medication abortion. For procedures prior to approximately 15 weeks LMP, the physician will use 3 non-sterile gloves per patient, and assisting staff might use 2-3 additional pairs of non-sterile gloves per patient. For procedures beyond 15 weeks LMP, the physician typically uses a gown, face shield, and one pair of sterile gloves, and other staff assisting in the procedure wear non-sterile gloves. For some procedures beyond 15 weeks LMP, Southwestern may also use reusable eyewear. Staff assisting with abortion procedures will typically wear 1-2 pairs of shoe coverings every day.

20. Based on Southwestern's patient load, in an average week, we use the following PPE: a few boxes of non-sterile gloves; approximately 15 pairs of sterile gloves for procedures after 15 weeks LMP; approximately 15 gowns; around 24 pairs of shoe coverings per day; and a handful of simple surgical masks and reusable eyewear.

21. The clinic has a small number of N95 masks on hand. In early March, when the clinic was taking action addressing the COVID-19 pandemic, we were in touch with Dallas County Health and Human Services who recommended that we keep some N95 masks on site.

Harm to Southwestern and our Patients:

22. Although abortion is a very safe medical procedure, the health risks associated with an abortion procedure generally increase with gestational age. The complexity of the procedure, the PPE needed to complete the procedure, and the associated expense also increase with gestational age. Our patients generally seek abortion as soon as they are able, but many face

logistical obstacles that can delay their access to abortion care. Some come from over a hundred miles to receive care at our clinic. Patients need to schedule an appointment, gather the resources to pay for the abortion and related costs, and arrange transportation to a clinic, time off of work, and possibly childcare during appointments. Texas law requires them to make these arrangements multiple times for repeated trips to the clinic, even though most patients could safely obtain care in one visit. These existing delays already result in higher financial and emotional costs for our patients.

23. The COVID-19 pandemic has only exacerbated these burdens. It has limited public transit availability, caused layoffs and other work disruptions, shuttered schools and childcare facilities, and otherwise limited patients' options for transportation and childcare support during a time of recommended social-distancing.

24. Many recent patients have expressed gratitude that they were able to receive care with us. Many have expressed that they feel protected by the clinic's measures, and that they are relieved that the clinic was operating and continuing to provide services that are so time-sensitive and essential.

25. The patients whose appointments have been cancelled in light of the Executive Order and the Attorney General's interpretation have been extremely upset. Some of the dozens of patients we intended to see this week will be pushed out of eligibility for receiving a medication abortion. Others will be pushed into more complex procedures. And, some may not be able to return for their procedure with us at all.

26. Southwestern reasonably fears the Attorney General's threat of enforcement, given that the Attorney General may understand the Executive Order to prohibit procedural abortions that our physicians deem necessary to "correct a serious medical condition of … a patient who

without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician," as permitted by the Executive Order. Our physicians also reasonably fear that the Attorney General will understand the Order to prohibit medication abortions, despite the fact that these are not "procedures" under the common medical understanding of the term, and therefore do not fall within the terms of the Executive Order as understood by our medical staff.

27. Based on this enforcement risk, Southwestern is unsure how to proceed but plans to resume certain appointments where care does not involve new PPE.

28. If the Executive Order, as interpreted by the Attorney General, is enforced, it will delay and deny access to care for our patients. It will, as a result, harm patients' physical, emotional, and financial wellbeing and the wellbeing of their families.

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

Alicia Dewitt-Dick

Executed March 25, 2020

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, *et al.*, Plaintiffs, v. GREG ABBOTT, in his official capacity as Governor of Texas, *et al.*, Defendants.	No. 1:20-cv-00323-LY

DECLARATION OF JANE DOE IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

Jane Doe declares the following:

1. I am a 24-year-old college student and reside in Arlington, Texas. My appointment for an abortion in Texas on March 23, 2020, was cancelled because of Governor Abbott's Executive Order No. GA-09.

2. I submit this declaration in support of Plaintiffs' motion for a temporary restraining order followed by a preliminary injunction, which seeks to enjoin the Executive Order, as interpreted by the Texas Attorney General to ban most abortions in Texas as well as the Texas Medical Board's emergency amendment to 22 TAC § 187.57 ("Emergency Rule"), which imposes the same requirements as the Executive Order.

3. The facts I state here are based on my personal experience.

4. I am studying to become a secondary school teacher. I am planning to graduate this spring, but I have not gotten a teaching position yet.

5. Throughout college, I have been waiting tables part-time to support myself. About three weeks ago, I lost my job. Because of the COVID-19 outbreak, my restaurant announced that it would close down for eight weeks. It gave my coworkers and me information about applying for unemployment.

6. The same week I lost my job waiting tables, I became worried that I might be pregnant, even though my partner and I had been using birth control. Even before I took the at-home pregnancy test, I knew what I was going to do if it was positive. My partner and I were on the same page: This wasn't the right time. I had just lost my job. I was still in school. And I would need to start applying and interviewing for new jobs, which I expected would be harder to get if schools knew I was pregnant. And the biggest factor for me was simply that I didn't want to become a parent right now.

7. Coronavirus was all over the news, but I wasn't panicked about getting an appointment until I started calling abortion clinics. That's when I realized it was going to be tough to be seen in a timely fashion. Clinics kept telling me they couldn't see me for three or four weeks. Eventually, I secured an appointment in Fort Worth for the following week.

8. On Friday, March 20, I went to the clinic alone. I wasn't allowed to bring my partner because of the social distancing rules in place. In order to limit the number of patients inside the clinic, they actually had us sign in and wait in our cars. I sat in my car in the clinic parking lot for two hours before I was able to enter the building. Lots of other patients were waiting in their cars, too. Meanwhile, anti-abortion protesters stood about 10 feet away with signs and screamed at me and other patients. Later, I heard some nurses talking about how one woman got intimidated and drove off.

9. The appointment took five hours. The clinic gave me a sonogram over my belly and took blood. I was under 10 weeks pregnant so I qualified for a medication abortion. But Texas has a 24-hour waiting period, so the clinic couldn't let me go forward with the medication abortion that day even though I was certain of my decision and did not want to expose myself or anyone else to further risk of infection by having to come in for a second appointment. I had to come back for a second appointment. The soonest they could see me was in four days, which was Tuesday, March 24.

10. I was experiencing severe pregnancy symptoms. I was throwing up every day throughout the day. I wasn't able to study or eat. I felt so tired I could barely get out of bed. But I had no choice except to wait.

11. The night of Monday, March 23, I got a phone call from the clinic. My second appointment the next day was cancelled. The staffer told me that Gov. Greg Abbott halted all abortions in the state, claiming that medical supplies needed to be saved for other patients. I started to cry, and she cried too. She told me my only option at that point was to go out of state or delay my abortion and possibly be forced to have a baby. I was dumbfounded. I had a plan and everything came crashing down.

12. My partner was with me during the call, and we cried together afterward. Waiting to see if I could get an abortion later in Texas was not an option. I felt so sick. I didn't want to be pregnant one day longer, and I couldn't risk the possibility that I would run out of time to have an abortion while the outbreak continued. It seemed to be getting more and more difficult to travel. I also wanted to have a medication abortion so that I could do it in the privacy of my own home with my partner. Because of the clinic's rules during the COVID-19 outbreak, support companions weren't allowed in the clinic at all during procedural abortions. The clinic told me that medication

abortion wasn't available after ten weeks of pregnancy in Texas, so I knew that if I wanted to obtain a medication abortion, I needed to act quickly.

13. After the call, my partner and I began researching abortion restrictions in the states nearest Texas. Oklahoma has a 72-hour waiting period so I didn't want go there. I would have had to make more than one trip during the pandemic to meet that requirement and spend even more than I already had to.

14. We also looked at clinics in New Mexico, which would have been about a nine-hour drive each way for me. One was closed, and the others told me they couldn't see me for three or four weeks.

15. So then we looked at Colorado. I made a bunch of calls. On Monday night at about 11 p.m., I finally was able to make an online appointment with a clinic in Denver that could see me for a medication abortion on Thursday.

16. It's a 12-hour drive from my house and roughly 780 miles on the road one-way to Denver. My partner couldn't afford to miss work to accompany me. We were worried that he would have to explain to his boss why he was taking three days away from work. We didn't want to reveal to his employer that I was having an abortion. Luckily, my partner still has a job.

17. I couldn't have done the drive alone, and I was scared. My best friend came up on Tuesday from Austin to go with me. She also lost her job at a restaurant a couple weeks ago, so she was free.

18. My partner packed a box of sanitizing supplies for us to take on our trip, and we brought food to help avoid the need to make stops and risk exposure to the virus. My friend and I started out early on Wednesday and drove throughout the day. I rented the cheapest AirBnB I could find in Denver, and we wiped it down with disinfectant when we got there before sleeping.

19. My appointment was in the afternoon on Thursday, March 26. I noticed when we arrived at the clinic that two other cars with Texas license plates were in the parking lot. I had to go through the sonogram, bloodwork, and counseling all over again. But since Colorado does not have a 24-hour waiting period, the clinic I went to was able to give me the medication for my abortion without further delay. I took the first pill there and they sent me home with the second pill.

20. My friend and I started the twelve-hour drive home at 3:30 p.m. It felt like we were in a race against time because the clinic recommended that I take the second pill 24 to 30 hours after the time I took the first pill. We didn't want to take breaks or rest because I was worried about having my abortion in the car.

21. We drove about six hours but had to stop. It was pitch black, and we were exhausted. It was too dangerous for us to keep going. We had to rent a hotel room and stay there until the morning.

22. I got home in the afternoon on Friday, March 27. The provider in Colorado had recommended that I try to get as comfortable as possible before taking the second pill. I wanted to make sure I could eat a meal before taking the medication because I worried I would feel too nauseous afterwards to eat anything. By the time I took the second pill, nearly thirty hours had passed since the first one.

23. I was exhausted, and only then was I able to have my abortion. I passed the pregnancy Friday night at home with my partner.

24. With the cost of the AirBnB, gas, food, and parking, I've had to pay a lot more money out of pocket to get this abortion than I should have had to. I've spent nearly $1,000,

including the cost of the abortion itself, which is not covered by my health insurance. I've had to drain my savings to pay these costs.

25. Then there's the additional stress. Obviously, had this pregnancy not been a factor, I wouldn't be traveling during a pandemic. I already felt like it was risky for me to travel to a nearby clinic in Fort Worth to have my appointment. Instead, I was forced to drive across the country, to stop at dirty gas stations, to stay in an unfamiliar home, just to get health care. I feel like Texas put me, and my best friend, in danger.

26. With all of this stress and unexpected travel, I haven't been able to finish my application for unemployment benefits yet, so I probably won't get a check for at least another week. Even then the benefits will be a fraction of what I made working at a restaurant, and I now have fewer savings to cover the difference.

27. Despite everything I've been through this week, I feel incredibly grateful. I had savings. I have a partner with income. I don't already have kids. I had a best friend with a car who could go with me on a long, unexpected trip. So far I'm not sick. So many Texans don't have those things right now. And unlike me, many of them are much further along in pregnancy than I was. I have no idea how they're going to get the abortion care they need. Based on my own experience, I expect many will not. I know I was desperate, and desperate people take desperate steps to protect themselves.

28. I was born and raised in Texas. Right now, I feel let down by my government. I feel like Governor Abbott doesn't care about me or other patients who need essential abortion care. Why is my life not important enough to him and the other men making these decisions? Frankly, I feel like my constitutional rights were violated when I needed them the most.

29. I want to submit this declaration under a pseudonym because the information I am sharing in this action about my reproductive health care history is private and personal. I would not feel comfortable if this information and my name became public, especially because I will be looking for a job in the coming weeks. I also fear that if this information and my name became public, I would become a target for harassment by anti-abortion protestors.

30. I swear under penalty of perjury that the foregoing is true and correct.

Executed March 29, 2020

/s/ Jane Doe*
Jane Doe

*I have signed a copy of this declaration with my actual name and given it to Plaintiffs' attorneys for their records.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE; *et al.*,	)	
	)	CIVIL ACTION
Plaintiffs,	)	
	)	CASE NO. 1:20-cv-323-LY
v.	)	
	)	
GREG ABBOTT, in his official capacity as Governor; *et al.*,	)	
	)	
Defendants.	)	

DECLARATION OF ANDREA FERRIGNO

ANDREA FERRIGNO hereby declares under penalty of perjury that the following statements are true and correct:

1. I am the Corporate Vice-President with Whole Woman's Health ("WWH"), a plaintiff in this case.

2. WWH is a consortium of limited liability companies, each incorporated under Texas law. The consortium includes a property management company, healthcare management company specializing in the management of abortion clinics, and a network of abortion clinics.

3. WWH currently owns and operates two abortion clinics in Texas, one in Fort Worth (the "Fort Worth Clinic") and one in McAllen (the "McAllen clinic"). WWH also owns and operates an abortion clinic in Baltimore, Maryland; Minneapolis, Minnesota; and Alexandria, Virginia.

4. My responsibilities as Corporate Vice-President include ensuring that each clinic complies with all statutes and regulations concerning the provision of the health services they offer, including abortion care, as well as recruiting physicians.

5. I have worked at WWH in a variety of roles since 2004, when I first joined as a Patient Advocate. As a result, I am well-versed in abortion clinic operations and patient care.

6. I provide the following testimony based on personal knowledge and review of WWH's business records.

Provision of Abortion Care at the WWH Clinics in Texas

7. Both the Fort Worth and McAllen clinics offer surgical abortions up to 17.6 weeks gestation, as measured from the first day of a patient's last menstrual period ("lmp"). Texas law prohibits licensed abortion facilities from providing surgical abortions past this gestational age. *See* Tex. Health & Safety Code § 171.004.

8. Both clinics also offer medication abortions up to 10 weeks lmp. Texas law prohibits the provision of medication abortion past this gestational age. *See* Tex. Health & Safety Code § 171.063(a)(2).

Use of PPE in WWH Clinics in Texas

9. Texas law requires abortion patients who live within 100 miles of a licensed abortion facility to make two trips to obtain care. *See* Tex. Health & Safety Code § 171.012(a)(4), (b). During the first visit, we must provide the patient with State-mandated information and perform an ultrasound examination. *See id.* The physician cannot provide the patient an abortion until the second visit. *See id.*

10. There is minimal use of personal protective equipment ("PPE") at the WWH clinics in Texas. Physicians do not use it to provide medication abortions and use sterile gloves and

surgical gowns to provide surgical abortions. Some physicians also use surgical masks, disposable shoe covers and reusable goggles for dilation & evacuation ("D&E") abortions.

11. Additionally, physicians do not use PPE to perform an abdominal ultrasound examination before an abortion and use only gloves to perform a transvaginal ultrasound examination before an abortion.

12. After a surgical abortion, a staff member examines the tissue removed from the patient in the pathology laboratory. To do so, the staff member may use gloves, a surgical gown, face shield, or disposable shoe covers.

13. The WWH clinics in Texas do not have or intend to acquire any N-95 respirators, which are face coverings designed to block at least 95 percent of very small test particles.

14. Our abortion patients rarely require hospitalization.

WWH's Response to the COVID-19 Public Health Crisis

15. WWH has adopted certain policies to help ensure the safety of its patients and staff during the COVID-19 public health crisis.

16. We screen staff members for symptoms of COVID-19 and require anyone who is exhibiting them or has been exposed to someone with a confirmed case to self-quarantine for at least fourteen consecutive days.

17. Additionally, staff members screen all potential patients by phone for symptoms of COVID-19. If a patient is exhibiting symptoms, we ask them to self-quarantine, contact their primary care provider, and not visit the clinic unless they have been asymptomatic for at least fourteen consecutive days.

18. Further, we limit the number of people in a clinic at any given time and help ensure patients keep a safe distance from each other in the waiting room and recovery area.

19. We also train staff on best practices to prevent the spread of infection and require them to observe strict practices for handwashing and disinfecting surfaces. Texas law prohibits the provision of State-mandated information using telemedicine. *See, e.g.*, Tex. Occ. Code § 111.005(c); Tex. Health & Safety Code § 171.063(c); 25 Tex. Admin. Code § 139.53(b)(5).

Effect of the Governor's Executive Order

20. On March 22, 2020, Governor Abbott issued Executive Order GA-09 ("Executive Order"), which concerns hospital capacity during the COVID-19 public health crisis, and applies until 11:59 p.m. on April 21, 2020, assuming it is not renewed. The Executive Order directs "all licensed health care professionals and all licensed health care facilities" to "postpone all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician." *Id.* at 1. The Executive Order clarifies that the prohibition does not apply to "any procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster." *Id.*

21. The Executive Order does not define PPE. We at WWH understand PPE to include surgical masks, N-95 respirators, sterile and non-sterile gloves, disposable protective eyewear, surgical gowns, and disposable shoe covers.

22. Both the Fort Worth and McAllen clinics are willing and able to continue providing abortion care consistent with the Executive Order.

23. On March 23, 2020, however, WWH received a copy of an email from the Texas Office of the Attorney General announcing a press release by Attorney General Paxton, entitled

"Health Care Professionals and Facilities, Including Abortion Providers, Must Immediately Stop All Medically Unnecessary Surgeries and Procedures to Preserve Resources to Fight COVID-19 Pandemic."

24. The press release states that the Executive Order applies to "all surgeries and procedures that are not immediately medically necessary," including "most scheduled healthcare procedures that are not immediately medically necessary such as orthopedic surgeries or any type of abortion that is not medically necessary to preserve the life or health of the mother." It states that a "[f]ailure to comply with an executive order issued by the governor related to the COVID-19 disaster can result in penalties of up to $1,000 or 180 days of jail time" and warns that "[t]hose who violate the governor's order will be met with the full force of the law."

25. WWH's clinics in Texas were concerned that they would be prosecuted given the Attorney General's interpretation of the Executive Order as prohibiting "any type of abortion" even though the Executive Order permits abortions that physicians have determined are necessary to "correct a serious medical condition of … a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician," and/or those that "would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 health disaster."

26. On March 24, the Fort Worth Clinic cancelled appointments for 13 abortion patients, who now are unable to obtain care anywhere in Texas. The following day, the clinic cancelled another 18 appointments for abortion patients, who now are unable to obtain an abortion in the State.

27. On March 24, the McAllen Clinic cancelled appointments for two abortion patients, who now are unable to obtain care anywhere in Texas. The following day, the clinic cancelled

another two appointments for abortion patients, who now are unable to obtain an abortion in the State.

28. People continue to seek appointments at both clinics. We must turn them away unless we are certain that no aspect of their care will involve the use of PPE. Between today and April 21, 2020, we anticipate turning away over 100 patients from the Fort Worth Clinic and at least 40 patients from the McAllen Clinic.

29. Each of our abortion clinics has a maximum capacity based on the size of our facility and the availability of our physicians. The maximum capacity of the Fort Worth Clinic is 130 patients per week and the maximum capacity of the McAllen Clinic is about 60 patients per week. Even if we were able to resume abortion care on April 22, 2020, it would take us a significant amount of time to treat all of the patients that we will have to turn away between now and then, in addition to our regular patient load.

Impact on Patients

30. A majority of the patients at the Fort Worth Clinic are people of color and Spanish speakers. They hail from all over Texas.

31. A majority of the patients at the McAllen Clinic are Spanish speakers and many face immigration-related restrictions on traveling outside of the Rio Grande Valley.

32. The patients at both clinics seek abortion care for a variety of reasons. Many are low-income, uninsured, and the parents of dependent children.

33. And many would suffer substantial burdens if they were forced to seek abortion care out-of-state ordinarily. Such long-distance travel is virtually impossible now due to travel restrictions, more severe financial constraints for those in need of abortion care, school closures, and the unlikelihood of finding childcare.

34. Consequently, our patients and would-be patients will be forced to live with an unwanted pregnancy for an indefinite amount of time—if they are able to obtain an abortion at all. This can involve physical symptoms, such as morning sickness, considerable stress and anxiety, and the increased possibility that an abusive partner or family member will learn of the pregnancy.

35. People who are delayed past ten weeks lmp will no longer be able to obtain a medication abortion. *See* Tex. Health & Safety Code § 171.063(a)(2). Similarly, those who are delayed past 14-16 weeks lmp will no longer be able to obtain an aspiration abortion, a type of surgical abortion, and will instead have to receive a D&E, which is a lengthier and more complex procedure. Those who are pushed past 18 weeks lmp, *see* Tex. Health & Safety Code § 171.004, will no longer be able to obtain an abortion at an abortion clinic, while those who are delayed past 22 weeks lmp will no longer be able to obtain an abortion in Texas at all, absent a medical emergency. *See* Tex. Health & Safety Code § 171.044.

36. The medical risks of abortion and pregnancy, as well as the costs of abortion care, increase with gestational age.

37. Thus, the patients that WWH will be forced to turn away for fear of prosecution will suffer in significant and lasting ways.

Dated: March 25, 2020

/S/Andrea Ferrigno
Andrea Ferrigno
Corporate Vice-Present
Whole Woman's Health

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, *et al*., Plaintiffs, v. GREG ABBOTT, in his official capacity as Governor of Texas, *et al*., Defendants.	No. 1:20-cv-00323-LY

DECLARATION OF CLORA JOHNSON IN FURTHER SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Clora Johnson, declare as follows:

1. I am the General Manager for Plaintiff Planned Parenthood South Texas Surgical Center, where I oversee the operations of three facilities that provide abortion care.

2. I submit this declaration in further support of Plaintiffs' motion for a preliminary injunction, which seeks to enjoin Executive Order No. GA-09, as applies to previability abortion care, as well as the Texas Medical Board's emergency amendment to 22 TAC § 187.57 ("Emergency Rule"), which imposes the same requirements.

3. The facts I state here are based on the conversations I have had directly with patients to cancel their abortion appointments after the Texas Attorney General issued his press release regarding the Executive Order, as well as conversations I had on March 31, 2020, after the Fifth Circuit Court of Appeals stayed the District Court's temporary restraining order. If called and sworn as a witness, I could and would testify competently thereto.

4. As of the end of the day on March 31, 2020, PPST's health centers had cancelled 112 abortions as a result of the Executive Order.

5. I have worked for 19 years with patients who are facing some of the most difficult circumstances of their lives—and so I am accustomed to talking to people in crisis. However, the conversations I have had over the last few days, when telling people that their appointments are suddenly cancelled and that they can no longer obtain abortion services in Texas, have been some of the most difficult conversations of my life.

6. Almost every patient I have spoken with has cried and all have been devastated.

7. Many of these patients have lost their jobs because of the pandemic and they told me they do not know how they are supposed to continue a pregnancy while trying to support themselves and their families without a job. Some patients who have jobs are concerned that their pregnancies will cause them to lose their jobs, particularly where they are suffering pregnancy-related symptoms that make it difficult for them to continue working. They do not know how they are going to survive or how they are supposed to support themselves and their families, let alone support a pregnancy.

8. I know from conversations that at least some patients, after being denied care in Texas, travelled out of state, including by air travel, to obtain their abortion care. I know of at least four patients who traveled to Colorado to obtain care by plane. Two of these four patients said that they were afraid of flying during the COVID-19 pandemic, but that they had no other choice.

9. I know of at least three patients who traveled to New Mexico—roughly an eleven hour drive—though my understanding is that appointments there are scarce.

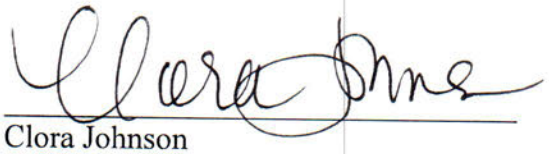
10. I know that at least three of the patients who traveled out of state were forced to do so because their pregnancies were so far along that they could not wait until the Executive Order's current expiration date in order to obtain care (even assuming the order does not get extended). These are only the patients who have told us that they are travelling out of state, I can only imagine how many others of our patients who have been turned away are currently trying to obtain out-of-state abortion care.

11. Every time I have to call one of these patients to cancel an appointment, I know it is causing them to experience a major change in their life, one that could seriously harm them, their health and their future. I do not know what to say to them—what do I even say to someone whose future I'm throwing into tumult? I can only apologize that they have to go through this.

12. In my role, I am familiar with how abortion care is scheduled in our health centers. Although we try very hard to schedule patients as quickly as we can, sometimes that is not possible, even in the absence of a pandemic. Even if the Executive Order is not extended beyond its current expiration date, I am worried that all the patients who have not been able to get abortion care will suddenly try to get appointments at the same time, and that this will create a multi-week backlog. If that happens, not all patients will be able to receive care, and many others will be delayed far longer than the Executive Order requires.

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

Executed April 1, 2020



Clora Johnson

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, et al., Plaintiffs, v. GREG ABBOTT, in his official capacity as Governor of Texas, et al., Defendants.	No. 1:20-cv-00323-LY

DECLARATION OF JESSICA KLIER IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

JESSICA KLIER, declares under penalty of perjury that the following statements are true and correct:

1. I am the Administrator at Austin Women's Health Center and Brookside Women's Medical Center, a position that I have held for 16 years. Along with the Medical Director, I provide overall leadership for the clinic. My responsibilities include carrying out the clinic's organizational goals, developing and implementing clinic policies and procedures with operational oversight of financial and budgetary activities, and ensuring compliance with all regulatory agencies governing health care delivery.

2. Austin Women's Health Center is a licensed abortion facility and Brookside Women's Medical Center is a gynecological and primary care practice. Together, these two facilities (collectively "Austin Women's") have provided high-quality reproductive services to Texas women for over 40 years. Austin Women's provides medication abortion up to 70 days of gestation and procedural abortions (sometimes referred to as "surgical abortions") up to 17

weeks, 6 days as dated from the first day of the patient's last menstrual period. Austin Women's also provides contraception, miscarriage management, and gynecologic surgical procedures, including colposcopies, biopsies, and loop electrosurgical excision procedures ("LEEPs"), in which a layer of cervical tissue is removed to diagnose and treat cancer or precancerous cells.

3. I submit this declaration in support of Plaintiffs' motion for a temporary restraining order followed by a preliminary injunction, which seeks to enjoin Executive Order No. GA-09 (the "Executive Order"), as interpreted by the Texas Attorney General to ban all previability abortion procedures in the state except where immediately necessary to protect the life or health of a pregnant person. I have reviewed the Executive Order and a press release by the Texas Attorney General interpreting it.

4. The facts I state here are based on my experience, my review of Austin Women's business records, information obtained in the course of my duties at Austin Women's, and personal knowledge that I have acquired through my service at Austin Women's.

5. On March 22, 2020, Texas Governor Greg Abbott issued the Executive Order, relating to hospital capacity during the COVID-19 pandemic. That order is in effect until 11:59 p.m. on April 21, 2020, although it may be extended. It directs "all licensed health care professionals and all licensed health care facilities" to "postpone all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician." *Id.* at 1. The Executive Order states that this prohibition does not apply to "any procedure that, if performed in accordance with the commonly accepted standard of clinical

practice, would not deplete the hospital capacity or the personal protective equipment ["PPE"] needed to cope with the COVID-19 disaster." *Id.*

6. Although the order does not define PPE, I understand that term to refer to surgical masks, N95 respirators, sterile and non-sterile gloves, disposable protective eyewear, disposable gowns, and disposable shoe covers. Austin Women's stocks surgical masks, non-sterile gloves, disposable protective eyewear, disposable gowns, and disposable shoe covers. We also have a small number of N95 respirators that we generally do not use.

7. On Monday, March 23, 2020, Austin Women's received a copy of an email from the Texas Office of the Attorney General announcing a press release by Attorney General Ken Paxton, entitled "Health Care Professionals and Facilities, Including Abortion Providers, Must Immediately Stop All Medically Unnecessary Surgeries and Procedures to Preserve Resources to Fight COVID-19 Pandemic."

8. The press release states that the Executive Order applies to "all surgeries and procedures that are not immediately medically necessary," including "most scheduled healthcare procedures that are not immediately medically necessary such as orthopedic surgeries or any type of abortion that is not medically necessary to preserve the life or health of the mother." The release invokes the order's application to abortion providers four times. It states that a "[f]ailure to comply with an executive order issued by the governor related to the COVID-19 disaster can result in penalties of up to $1,000 or 180 days of jail time" and warns that "[t]hose who violate the governor's order will be met with the full force of the law."

9. In 2019, Austin Women's performed 3058 abortions, 1601 of which were medication abortions.

10. In January and February 2020, Austin Women's performed 570 abortions, 309 of which were medication abortions.

11. Neither medication nor procedural abortion requires extensive, if any, PPE or otherwise would deplete PPE necessary to address the current pandemic. Before the COVID-19 outbreak, Austin Women's used no PPE for medication abortion, and limited PPE for procedural abortions—non-sterile gloves and disposable shoe covers for most procedures, with the addition of gowns, face masks, and face shields for second trimester procedures.

12. An ultrasound or laboratory exam, including one that accompanies medication or procedural abortion at Austin Women's, requires only non-sterile gloves, similar to what are used in nearly all medical visits by health care providers.

13. Since the COVID-19 outbreak began, Austin Women's has taken extra steps to conserve PPE while protecting our patients and staff from potential sources of transmission. Austin Women's primary physician, for example, has been wearing and reusing a single N95 mask during all face-to-face interactions with patients and switched to using washable gowns during procedural abortions.

14. We have also taken numerous steps to help prevent the spread of COVID-19 infection in our facility. We have taken measures to ensure social distancing, including utilizing the large outdoor space around our clinic, where, where the weather is pleasant, we have set up chairs at least six feet apart. Inside the facility we have similarly spaced chairs in the waiting room at least six feet apart. We now ask patients to fill out paperwork and wait for their procedure in their car. In addition, although we normally welcome support companions accompanying abortion patients, we have decided not to allow such companions (except parents

accompanying minors or language translators) to enter our facility to reduce the number of overall people exposed to one another.

15. We have also begun spacing out appointments to reduce crowding in our facility and have deactivated the automatic online appointment feature on our website to prevent double booking. We have also changed the patient flow in our facility so that each patient stays in their assigned patient room for the duration of their visit, instead of going back and forth to the waiting room in between visits with different staff members.

16. We have also been screening patients both on the phone when they make their appointment and upon entry for potential infection, including: asking each patient if she has a fever or a cough, asking if she has been exposed to potential COVID-19 patients, and taking each patient's temperature upon entry to the facility. Beginning this week, we were planning to start screening staff members each day for fever and other potential symptoms.

17. Based on the risk of enforcement of the Executive Order, we have already had to cancel nearly 100 abortion patient appointments, though we are still seeing some patients including for follow-ups and urgent gynecological care. If we are unable to see certain patients for the rest of the week, we will need to cancel dozens of additional patient appointments.

18. Many, if not all of these patients, in addition to the patients Austin Women's planned to serve through April 21, will be significantly burdened by the delays in their access to care. Many will be unable to access abortion at all, while others will be forced to travel out of state. All will suffer increased risks to their health by the delay in access to abortion care. Many will also face increased costs related to abortion, as their abortion access is pushed to later gestational points when abortion is more expensive and may require a two-day procedure, instead of one, and thus additional use of PPE.

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

Jessica Klier

Executed March 25, 2020

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, *et al*., Plaintiffs, v. GREG ABBOTT, in his official capacity as Governor of Texas, *et al*., Defendants.	No. 1:20-cv-00323-LY

DECLARATION OF KEN LAMBRECHT IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

I, Ken Lambrecht, declare as follows:

1. I am the CEO of Planned Parenthood Greater Texas, Inc. ("PPGT") as well as of its related entity, Planned Parenthood of Greater Texas Surgical Health Services ("PPGTSHS"). I am responsible for the management of these organizations and therefore am familiar with our operations and finances, including the services we provide and the communities we serve.

2. PPGT is a not-for-profit organization incorporated in Texas and headquartered in Dallas, Texas. It operates health centers throughout Central and North Texas, including Austin, Dallas, El Paso, Fort Worth, Paris, Tyler, Waco, and surrounding communities. PPGT provides comprehensive reproductive health care services, including birth control, emergency contraception, testing and treatment for sexually transmitted infections (STIs), pregnancy testing and prenatal referrals, clinical breast exams, breast and cervical cancer screenings, PrEP, PEP,

colposcopy, Loop Electrosurgical Excision Procedure (LEEP), and condyloma treatment. PPGT also provides Gender Affirming Hormone Therapy and hormone replacement therapy.

3. An ancillary of PPGT, PPGTSHS, also provides medication and procedural abortion at three health centers.

4. I submit this declaration in support of Plaintiffs' motion for a temporary restraining order followed by a preliminary injunction, which seeks to enjoin Executive Order No. GA-09, as interpreted by the Texas Attorney General to ban all previability abortion in the state except where immediately necessary to protect the life or health of a pregnant person, as well as the Texas Medical Board's emergency amendment to 22 TAC § 187.57 ("Emergency Rule"), which imposes the same requirements as the Executive Order. I am familiar with the Executive Order, a press release by the Texas Attorney General interpreting it, and the Emergency Rule.

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

The Executive Order and Threatened Enforcement

6. On March 22, 2020, Texas Governor Greg Abbott issued the Executive Order, relating to hospital capacity during the COVID-19 pandemic. That order is in effect until 11:59 p.m. on April 21, 2020, although it may be extended. It directs "all licensed health care professionals and all licensed health care facilities" to "postpone all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician."

Id. at 1. The Executive Order states that this prohibition does not apply to "any procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment ["PPE"] needed to cope with the COVID-19 disaster." *Id.*

7. Although the order does not define PPE, I understand that term to refer to surgical masks, N95 respirators (a face covering that is designed to block at least 95 percent of very small test particles and which, when used appropriately, is a more effective filtration system than a surgical mask), sterile and non-sterile gloves, protective eyewear, gowns, and shoe covers.

8. PPGTSHS has adopted a policy to implement the Executive Order, a true and correct copy of which is attached as Exhibit A. That policy permitted PPGTSHS to continue offering procedural and medication abortion, consistent with the Executive Order's purpose and plain language and the views of trusted national medical organizations.

9. On Monday, March 23, 2020, PPGTSHS received a copy of an email from the Texas Office of the Attorney General announcing a press release by Attorney General Ken Paxton that interprets the Executive Order and which threatens abortion providers with enforcement measures if they violate the order.

PPGTSHS' Provision of Abortion Care

10. In 2019 PPGTSHS performed 6,982 abortions. Of those, 1,643 occurred beyond 10 weeks LMP, and were therefore necessarily performed as procedural abortion. Of those 5,339 occurring before 10 weeks LMP, 1,668 were done by procedural abortion and the remainder by medication abortion.

11. In January and February 2020, PPGTSHS performed 924 abortions, 285 of which occurred beyond 10 weeks LMP and were therefore necessarily performed as procedural abortions.

Of those 639 abortions occurring before 10 weeks LMP, 197 were done by procedural abortion and the remainder by medication abortion.

12. Neither medication nor procedural abortion requires extensive PPE or otherwise would deplete PPE. In fact, for medication abortion, providing patients with the medication does not require the use of *any* PPE. And while procedural abortion at PPGTSHS requires the use of five non-sterile gloves for each procedure, a procedural mask that includes protective eyewear (one per provider per day, unless a mask becomes soiled), disposable gowns and hair cover (one per provider per day, unless they become soiled), and disposable shoe covers, only a small number of workers are physically present for these procedures or their preparation/recovery and therefore in need of PPE.[1] For an ultrasound or laboratory exam, including one that accompanies medication or procedural abortion, our providers currently use non-sterile gloves. PPGTSHS does not use or have any N95 respirators, which I understand are the PPE in shortest supply during the COVID-19 pandemic.

13. PPGTSHS does not provide inpatient care, nor is it set up to do so.

PPGTSHS' Efforts to Prevent COVID-19 Spread and Conserve Needed Resources

14. PPGTSHS is committed to doing its part to reduce the spread of COVID-19 and to otherwise help ensure that our public health system has sufficient resources to meet the challenge of responding to a potential surge of illness.

15. Since the COVID-19 outbreak, PPGTSHS has taken extensive steps to preserve much-needed medical resources that are in short supply during the pandemic and help prevent the

[1] Per CDC guidance, PPGTSHS provides patients for whom there is a concern for COVID-19 or other upper respiratory disease with a mask. Ctrs. for Disease Control & Prevention, *Frequently Asked Questions about Personal Protective Equipment* (Mar. 14, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirator-use-faq.html.

spread of COVID-19 in the communities where we offer services. Even before the Governor's order, for example, we had excluded residents and medical students from observing or participating in surgeries or procedures, which reduced the number of individuals requiring PPE. As a result of the outbreak, we have reduced our patient volume to ensure that we comply with current social-distancing recommendations. In addition, although in normal times we welcome support companions accompanying abortion patients, we have decided not to allow such companions (except parents accompanying minors) to enter our health centers in order to reduce the number of overall people exposed to one another.

16. We have also made changes to the flow of patient care. Before patients may enter a health center, we screen them for COVID-19 symptoms, including by checking for fever. Only those individuals who are positively screened can proceed to the front desk to check in and provide their phone number. Patients are then asked to wait in their cars, where a nurse will call them to do as much intake as possible by phone. Patients are only permitted to reenter the health center when a room has opened for them and a clinician is available to see them.

Harms Caused by the Executive Order and the Attorney General's Interpretation of It

17. PPGTSHS reasonably fears the Attorney General's threat of enforcement, given that the Attorney General may understand the Executive Order to prohibit procedural abortions that PPGTSHS's physicians have determined are necessary to "correct a serious medical condition of . . . a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician," as permitted by the Executive Order. It also reasonably fears that the Attorney General will understand the order to prohibit medication abortions, despite the fact that these are not "procedures" and therefore do not fall within the terms of the Executive Order at all.

18. Based on this enforcement risk, PPGTSHS cancelled twenty-two medication abortions and six procedural abortions on Tuesday, March 24. Even if each one of these patients were able to access abortion after the order's current expiration date (i.e., even if the order is not extended), many of the medication abortion patients would require procedural abortions instead (and correspondingly greater amounts of PPE), and five of the six procedural abortion patients would require a comparatively more complicated procedural abortion method known as the D&E (or Dilation & Evacuation) technique. That technique requires more time in the clinic and a larger number of staff than aspiration abortion. Moreover, because these patients would continue to be pregnant for a longer period of time, they would be at increased risk of negative health outcomes if they are diagnosed with COVID-19.[2]

19. Between Wednesday and Friday of this week, PPGTSHS has seventeen medication abortions and eleven procedural abortions scheduled. Even if each one of these patients were able to access abortion after the order's current expiration (i.e., it is not extended), many medication abortion patients would require procedural abortions instead (and correspondingly greater amounts of PPE). One of the procedural abortion patients would be beyond the legal gestational limit for abortion in Texas, another would be within days of that limit, and two others would be more than twenty weeks pregnant.

20. PPGTSHS will cancel non-emergency future surgical abortion appointments unless and until the Executive Order and Emergency Rule expire or are rescinded, or unless the Court grants relief. Additionally, because of the AG's interpretation of the Executive Order, we have

[2] Ctrs. for Disease Control & Prevention, *Information for Healthcare Providers: COVID-19 and Pregnant Women* (last updated Mar. 16, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/pregnant-women-faq.html.

cancelled all non-emergency medication abortions until we obtain clarity on the scope of the Executive Order or the Court grants relief.

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

Ken Lambrecht

Executed March 25, 2020

EXHIBIT A

Planned Parenthood of Greater Texas, Inc.
Policy In Response to Texas Executive Order GA 09
Relating to Hospital Capacity During the COVID-19 Disaster

PURPOSE

In light of the global pandemic of COVID-19, Governor Abbott signed Executive Order ("EO") GA 09 on March 22, 2020, attached, which is in effect until 11:59 p.m. on April 21, 2020. EO GA 09 directs "all licensed health care professionals and all licensed health care facilities" to "postpone all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician." EO GA 09 goes on to state that this prohibition does not apply to "any procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID- 19 disaster."

POLICY

To comply with EO GA 09, Planned Parenthood of Greater Texas, Inc. (PPGT) hereby establishes the following policies which shall remain in effect until rescinded or modified:

1. Surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician, and which would deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster, are not to be scheduled while this policy is in effect.

2. Physicians shall determine on a case-by-case basis whether a procedure that would deplete hospital capacity or personal protective equipment needed to cope with COVID-19 can be delayed without risk for serious adverse medical consequences or death.

3. PPGT's physicians have made the determination that abortion is a time-sensitive service and an essential component of comprehensive care, for which a delay of 30 days, or even less, increases the risks to patients, or make abortion completely inaccessible, and that such delay in accessing or inability to access an abortion exposes patients to risk of a serious adverse medical consequence.

4. In making this determination, PPGT's physicians considered or will consider the following:

a. The purpose and text of EO GA 09, namely: concern for "a shortage of hospital capacity or personal protective equipment" that could "hinder efforts to cope with the COVID-19 disaster."

b. The stated 30-day duration of a the delay, taking into account the Ambulatory Surgery Center Association's "COVID-19: Guidance for ASCs for Necessary Surgery," issued March 18, 2020, which states that consideration of whether delay of a surgery is appropriate must account for risk to the patient of delay, "including the expectation that a delay of 6–8 weeks or more may be required to emerge from an environment in which COVID-19 is less prevalent."

c. The fact that pregnancy has a duration of approximately forty weeks, as measured from the first day of a woman's last menstrual period (LMP) and that most abortions are banned in Texas beginning at 20 weeks gestation. Tex. Health & Safety Code § 171.044.

d. The fact that, while abortion is an extremely safe medical procedure, delay increases the risk to the health of the patient. *See, e.g.,* Nat'l Acads. of Scis. Eng'g & Med., The Safety & Quality of Abortion Care in the United States at 77-78, 162-63 (2018). Delay is of particular concern during the COVID-19 crisis, given guidance from the Center for Disease Control ("CDC") and American College of Obstetricians and Gynecologists ("ACOG") that pregnant women may be at heightened risk of severe illness, morbidity, or mortality from viral respiratory infections such as COVID-19.[1]

e. The Joint Statement by the American College of Obstetricians and Gynecologists ("ACOG"), the American Association of Gynecologic Laparoscopists, *et al.*, on Elective Surgeries[2], issued March 16, 2020, which states that "Obstetric and gynecologic procedures for which a delay will negatively affect patient health and safety should not be delayed. This includes gynecologic procedures and procedures related to pregnancy for which delay would harm patient health. Obstetrician–gynecologists and other health care practitioners should be aware of

[1] Available at https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/03/novel-coronavirus-2019 and https://www.cdc.gov/coronavirus/2019-ncov/hcp/pregnant-women-faq.html

[2] Available at https://www.acog.org/news/news-releases/2020/03/joint-statement-on-elective-surgeries

the unintended impact that policies responding to COVID-19 may have, including limiting access to time-sensitive obstetric and gynecological procedures."

f. The Joint Statement by the ACOG, the American Board of Obstetrics & Gynecology, *et al.,* on Abortion Access During the COVID-19 Outbreak[3], issued March 18, 2020, which states that to "the extent that hospital systems or ambulatory surgical facilities are categorizing procedures that can be delayed during the COVID-19 pandemic, abortion should not be categorized as such a procedure" because it "is an essential component of comprehensive health care" and "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks [to patients] or potentially make it completely inaccessible."

3. All procedures which cannot be reasonably delayed and thus which *are* scheduled and performed, in accordance with the above considerations and in compliance with EO GA 09, shall be performed while making every effort to conserve PPE and to reduce the possibility of spread and transmission of COVID-19.

Kenneth S. Lambrecht

[NAME, TITLE]

President & CEO

PP Greater TX

[3]Available at https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak

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AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, *et al.*, Plaintiffs, v. GREG ABBOTT, in his official capacity as Governor of Texas, *et al.*, Defendants.	No. 1:20-cv-00323-LY

DECLARATION OF JUDY LEVISON, M.D., M.P.H., IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Judy Levison, M.D., M.P.H., do declare as follows:

1. I am a board-certified obstetrician and gynecologist ("OB/GYN") and have practiced medicine in the field of obstetrics and gynecology for thirty-eight years. In that time, I have delivered many thousands of babies. I am licensed to practice medicine in the State of Texas and am in good standing with the Texas Medical Board. A copy of my curriculum vitae is attached as Exhibit A.

2. I graduated from Tufts University School of Medicine, obtained a Master's Degree in Public Health from the University of Texas School of Public Health, and completed my medical residency in obstetrics and gynecology at the University of Washington.

3. I am a member of the American College of Obstetricians and Gynecologists ("ACOG") and the American Academy of HIV Medicine ("AAHIVM").

4. I make this declaration based upon my education, training, practical experience, and personal knowledge that I have obtained as an OB/GYN; my attendance at professional conferences; review of relevant medical literature; and conversations with other medical professionals. I am competent to testify thereto.

5. The statements in this declaration are attributable solely to me; I do not speak on behalf of my employer or any institution or organization with which I am affiliated.

6. As a result of my extensive experience in the field of obstetrics and gynecology, as both an academic and a practitioner, I am familiar with the standard of care for both abortion and obstetrics, including prenatal care and labor and delivery. Specifically, I am familiar with the hospital resources and the amount of personal protective equipment ("PPE") required to provide such care safely. I am also quite familiar with the complications that can arise during pregnancy and childbirth.

7. Based on my experience and knowledge of obstetrics and gynecology practice in Texas, the provision of abortion care will not deplete hospital capacity or PPE needed to fight COVID-19.

Abortion Care Does Not Deplete Hospital Capacity

8. Abortion care does not deplete hospital capacity. Pregnant patients need medical care, whether that care is abortion care, prenatal care, or delivery. Each of those things *may* lead to hospitalization, but abortion care is significantly less likely to result in hospitalization than continuing to carry a pregnancy, particularly doing so to term, or experiencing a serious pregnancy-related complication. Some common examples of potentially life-threatening pregnancy-related complications that will result in hospitalization include preeclampsia, placenta previa, and pulmonary embolism.

9. Carrying a pregnancy to term is a significant months-long medical event which, for the vast majority of people, culminates in a multi-day hospitalization. By contrast, abortion almost never requires hospitalization, either to provide abortion safely or to treat the rare complication that arises. Indeed, many complications from abortion can be treated out-patient, at the clinic, and do not require hospitalization.

10. Moreover, even leaving labor and delivery aside, a pregnancy is much more likely to result in a visit to a hospital than an abortion. Based on published literature and my experience, at least twenty percent of pregnant patients will visit a hospital at some point prior to delivery, and some patients will visit the hospital for evaluation or treatment on multiple occasions.[1] By contrast, I rarely see patients hospitalized for abortion complications.

11. Furthermore, if a patient attempts a self-managed abortion using unsafe methods, this may result in hospital care as well. In Texas, abortion is all but banned after twenty-two weeks LMP. Thus, some patients cannot wait three weeks for the Executive Order's stated expiration in order to obtain a legal abortion. While some of those patients will likely try to travel out of state for care (despite the risks of traveling long distances during the COVID-19 pandemic), I fear others may turn to unsafe methods to try and induce their own abortions.

Abortion Care Does Not Deplete PPE Needed to Fight the COVID-19 Pandemic

12. More PPE is used in prenatal and intrapartum care than in abortion care, whether medication abortion or procedural abortion. As noted, pregnant people need medical care, whether

[1] *See, e.g.*, Shayna D. Cunningham et al., *Association Between Maternal Comorbidities and Emergency Department Use Among a National Sample of Commercially Insured Pregnant Women*, 24 Acad. Emergency Med. 940, 942 (2017); Kimberly A. Kilfoyle et al., *Non-Urgent and Urgent Emergency Department Use During Pregnancy: An Observational Study*, 216 Am. J. Obstetrics & Gynecology 181.e1 (2017); Urania Magriples et al., *Prenatal Health Care Beyond the Obstetrics Service: Utilization and Predictors of Unscheduled Care*, 198 Am. J. of Obstetrics & Gynecology 75.e1 (2008).

in the form of abortion care, prenatal care, or delivery. Abortion care uses less PPE than prenatal care, let alone care for a pregnancy complication or for labor and delivery.

13. Prenatal care generally involves multiple visits, which may include physical examinations (including pelvic exams), ultrasounds, and blood draws for genetic testing—each of which requires the use of, at the very least, one pair of disposable gloves per clinician seen.

14. Some pregnant patients require more, or different, prenatal care, which may involve more PPE, such as when there is a complication with the pregnancy or when the patient has other risk factors. Some conditions require substantially more blood draws, such as pregnant patients with HIV or preeclampsia. Each of those blood draws requires a set of disposable gloves.

15. If the Executive Order is extended beyond its current expiration date, it will result in even greater use of PPE. Labor and delivery requires substantial PPE, particularly given the number of medical staff involved in even uncomplicated deliveries. For a vaginal delivery, the patient will be assisted by, at the very least, a physician (or midwife) and a nurse, though frequently it will be four or more individuals. The primary personnel must wear PPE, including a gown, gloves, shoe covers, and often surgical masks. After an uncomplicated vaginal delivery, the patient and her baby typically remain in the hospital for about forty-eight hours.

16. Delivery by cesarean section ("C-section"), which is common, requires substantially more staff and more PPE than vaginal delivery, as a C-section is an abdominal surgery with an inpatient recovery period of two to four days. For a C-section, personnel involved will generally include an OB/GYN, an assistant, a scrub tech, a circulating nurse, an anesthesiologist, and very possibly a neonatal team. Each of these personnel generally wear PPE, including a surgical mask and gloves, with some wearing gowns and shoe covers as well.

17. For deliveries for patients with confirmed or suspected COVID-19 infection, all personnel wear full PPE, including masks, gloves, gowns, shoe covers, and face shields.

Preventing People from Obtaining Abortion Care Does Not Make Sense from a Public Health Perspective

18. I understand the need to conserve PPE and to reduce hospitalizations during this public health crisis. Like medical practitioners around the country, I am doing my part in my own practice. As required by the Executive Order, I am cancelling routine visits and procedures that can be delayed, based on my best medical judgment. However, pregnancy-related medical care is urgent and time-sensitive by its very nature. While some care can be provided remotely by telehealth, much prenatal and postpartum care cannot, nor can it wait. Thus, most prenatal and postpartum care is continuing, though measures are being taken to reduce the risk of transmission, including by spacing out appointments to ensure that waiting rooms are not crowded.

19. Typically, the full course of prenatal care may involve between ten and fourteen prenatal visits, but given the COVID-19 pandemic, my colleagues and I have attempted to reduce that number of visits where possible. Some visits we can conduct by telehealth, such as follow-up consultations, chart checks, or lab result reviews. Because obstetric care requires blood draws and ultrasounds, as well as other in-person diagnostics, it is not possible to conduct most prenatal appointments via telehealth.

20. In my opinion, preventing people from obtaining abortion care does not make sense from a public health perspective.

21. As described above, requiring people to continue unwanted pregnancies utilizes more PPE and more hospital resources than abortion care—particularly, but certainly not only, in the circumstance where people are required to carry those pregnancies to term. Indeed, even if

patients can ultimately obtain an abortion after the Executive Order expires, many will be so far along that they may require a two-day procedure, meaning that twice as much PPE will be used.

22. Moreover, it is my understanding that pregnant people with any upper respiratory infection may be more likely to experience serious symptoms from the disease than a non-pregnant patient, which in turn makes her more likely to need hospital care than someone who is not pregnant, and more likely to die.

23. Finally, if patients cannot obtain abortions in Texas, that will not stop most of them from seeking to terminate their pregnancies. Some will travel long distances during the pandemic to try and obtain care elsewhere. Some, I fear, will turn to unsafe means to induce their own abortions. Neither is a positive public health outcome.

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

Executed April 1, 2020

Judy Levison, M.D.

EXHIBIT A

Judy Levison, MD, MPH
Baylor College of Medicine
Northwest Community Health Center
1100 West 34th St.
Houston, TX 77018
[redacted]
jlevison@bcm.edu

I. GENERAL BIOGRAPHICAL INFORMATION

A. Personal

1. ***Name***: Judy Levison, M.D., M.P.H.
2. [redacted] citizenship: U.S.

B. Education

1. ***Undergraduate education***

1968-1972 Tufts University

Medford, Massachusetts

2. ***Medical education***

1972-1976 Tufts University School of Medicine
Boston, Massachusetts

3. ***Postgraduate training***

1977-1978 Internship, Internal Medicine
St. Elizabeth's Hospital (Tufts University affiliated hospital)
Brighton, Massachusetts

1978-1981 Residency, Obstetrics and Gynecology
University of Washington
Seattle, Washington

2005-2010 Masters in Public Health
University of Texas School of Public Health
Houston, Texas

C. Academic appointments

1. ***Faculty positions at BCM***

2015-present
Professor, Baylor College of Medicine, primary appointment to the Department of Obstetrics and Gynecology and secondary appointment to the Department of Family and Community Medicine

1-14-20

Judy Levison MD

2007-2015
Associate professor, Baylor College of Medicine, primary appointment to the Department of Obstetrics and Gynecology and secondary appointment to the Depar tment of Family and Community Medicine
2000-2007
Assistant professor, Baylor College of Medicine, Department of Family and Community Medicine with joint appointment to the Department of Obstetrics and Gynecology

2. ***Previous faculty positions at other institutions***

1996-1999
Assistant professor, Department of Obstetrics and Gynecology, Santa Clara Valley Medical Center, San Jose, California and Stanford University Medical Center, Stanford, California

3. ***Faculty appointments at other institutions while at BCM***

2014-present
Consultant to University of California San Francisco (UCSF) Clinical Care Center Perinatal Hotline

D. Other advanced training/experience

1. ***Formal sabbatical leave***: none
2. ***Other specialized training following academic appointment***

2005-2010 Masters in Public Health
University of Texas School of Public Health
Houston, Texas

E. Other information

1. ***Honors or awards***

a. 2004 BCM Department of Obstetrics and Gynecology Teaching award
b. 2005 Council on Resident Education in Obstetrics and Gynecology (CREOG) Excellent Resident Education Award
c. 2005 BCM Department of Obstetrics and Gynecology Teaching Award
d. 2006 BCM Department of Obstetrics and Gynecology Excellence in Resident Teaching Award
e. 2006 Bradley Scott Award for Excellence in HIV Care, Houston
f. 2010 American College of Obstetricians and Gynecologists (ACOG) Community Service Award, ACOG 58th Annual Clinical Meeting, San Francisco
g. 2011 BCM Obstetrics and Gynecology Residency Class of 2011 Humanitarian Award
h. 2012 BCM Family Medicine Residency Teaching Award
i. 2013 Houston Woman Magazine “Wise Woman” Award
j. 2014 BCM Fulbright and Jaworski Teaching Award
k. 2014 BCM Institute for Clinical and Translational Research (ICTR) Clinical Investigator Award
l. 2019 Inaugural Department of Obstetrics and Gynecology Professionalism Award

2. ***Board eligibility/certification***
1984 Board certified (lifetime), American Board of Obstetrics and Gynecology
1997 Voluntary recertification, American Board of Obstetrics and Gynecology
2006 Voluntary recertification, American Board of Obstetrics and Gynecology
2007 Voluntary recertification, American Board of Obstetrics and Gynecology
2008 Voluntary recertification, American Board of Obstetrics and Gynecology
2010 Voluntary recertification, American Board of Obstetrics and Gynecology
2013 Voluntary recertification, American Board of Obstetrics and Gynecology
2016 Voluntary recertification, American Board of Obstetrics and Gynecology
2018 Voluntary recertification, American Board of Obstetrics and Gynecology

2002-present Certification as HIV specialist, American Academy of HIV Medicine

3. ***Other non academic positions***

1981 – 1982
Attending physician
Group Health Cooperative
Seattle, Washington

1983 – 1995
Private Practice
Everett, Washington
Private practice with special interest in high risk obstetrics and gynecologic surgery

2004 Consultant to Secure the Future (prevention of mother to child transmission of HIV (PMTCT) projects):
Mbabane, Swaziland, March 2004 (three weeks)
Katima Mulilo, Namibia, November 2004 (four weeks)

2006 Consultant to American International Health Alliance (AIHA):
Krivy Rih, Ukraine (one week)

II. RESEARCH INFORMATION

A. Research support

1. Trichomonas and HIV

a. ***Title***: Trichomonas recurrence among HIV-positive women
b. ***Funding agency***: National Institutes of Health
c. ***Investigator relationship***: Co-principal investigator (site PI); principal investigators David Martin PI/Patty Kissinger –Project 4 PI
d. ***Dates of funding***: 01/01/07 through 08/31/09
e. ***Annual total direct cost*** $86,500

f. **NIH *grant*** to Tulane University/Louisiana State University (LSU) with subcontract from Tulane to BCM. Gulf South STI/Topical Microbicide Cooperative Research Center—Project 4/Project number 1 U19 AI61972-01

2. Prevention of Perinatal HIV Transmission

a. ***Title***: Texas Rapid-testing Implementation At Delivery (TRIAD) project—program originally developed to introduce rapid testing to Houston hospitals for patients who present with no prenatal care; now centered on education of clinicians in Texas about prevention of perinatal HIV transmission. Current focus: development of FIMR (Fetal and Infant Mortality Review) adapted for HIV—to analyze root causes of perinatal HIV transmission in Texas and direct findings to institutions that can effect change
b. ***Funding agency***: Centers for Disease Control (CDC) via Texas Department of Social and Health Services (DSHS)
c. ***Investigator relationship***: Principal investigator
d. ***Dates of funding***: 01/01/07 through present
e. ***Annual total direct cost*** $120,000-140,000
g. ***Grant*** from CDC to Texas Division of HIV/STD with contract to Harris Health System. Contract number 2007-021777-001

3. Education on HIV Perinatal Transmission Prevention

a. ***Title***: HIV Perinatal Transmission Prevention--development of five online interactive modules (2 hours of CME/CNE) to educate Texas obstetric providers and nurses about standard of care prenatal HIV and syphilis testing. Working in conjunction with Microassist to produce interactive videos
http://www microassist com/
b. ***Funding agency***: Centers for Disease Control (CDC) via Texas Department of Social and Health Services (DSHS)
c. ***Investigator relationship***: Principal investigator
d. ***Dates of funding***: 09/01/10-12/31/10
e. ***Annual total direct cost*** $55,824
f. ***Grant*** from CDC to Texas Division of HIV/STD with contract to Harris County Hospital District. ***Supplement*** to contract number 2007-021777-001

B. National scientific participation

1. ***Journal editorial boards***

2012-present: Have reviewed manuscripts for Journal for Acquired Deficiency Syndromes (JAIDS), American Journal of Obstetrics and Gynecology (AJOG), PLoS ONE, HIV/AIDS Research and Palliative Care, Lancet ID, Journal of Perinatology, Pediatrics, Sexually Transmitted Infections, Clinical Infectious Diseases, Journal of the International AIDS Society, Law and Ethics

2. ***Review panels***

2011-present: Elimination of Mother to Child Transmission of HIV Panel, sponsored by CDC

2013-present: Scientific Advisory Council to the Ryan White Planning Council and Community Planning Group, Houston, Texas

2013 and 2014: National Institutes of Health (NIH) Office of Aids Research: review of the women and girls section of the proposed FY 2015 Trans-NIH Plan for HIV Research

2013 and 2014: Invited judge, National Undergraduate Global Health Technologies Design Competition, Rice University, Houston, Texas

2013-present: Invited member, The DHHS Panel on Treatment of HIV-Infected Pregnant Women and Prevention of Perinatal Transmission/Working Group of the Office of AIDS Research Advisory Council (OARAC)—reviews and updates national perinatal HIV guidelines

3. ***Professional societies***

American Congress of Obstetricians and Gynecology
American Academy of HIV Medicine

4. ***Invited lectures/presentations*** (those marked with ***** are refereed)

National

***Levison, J.**, Peters, M., Hansen, I., Lewis, S. Mistakes We Made/Lessons We Learned. Poster and oral presentation at Elements of Success/International Conference on Adherence to Antiretroviral Therapy, Dallas, Texas, December 5, 2003.

***Levison, J.** and McFarlane, J. Houston, First to Implement Labor and Delivery Rapid HIV Testing in Texas. Poster presented at CDC Perinatal Conference on Promising Practices, Atlanta, Georgia, June 15-16, 2005.

***Levison, J.**, Peters, Y., and Moore, A. The HIV-Specific Ob-Checklist: Management and Communication Tool. Poster presented at Treatment & Management of HIV Infection in the United States Conference, Atlanta, Georgia, September 15-18, 2005.

***Levison, J.**, Peters, Y., and Trimble, D. A Model for Prenatal Care of the HIV-Positive Woman. Poster presented at Treatment & Management of HIV Infection in the United States Conference, Atlanta, Georgia, September 15-18, 2005.

*****Doyle, N., **Levison, J.**, and Gardner, M. Rapid HIV vs. ELISA Screening in a Low Risk Mexican American Population Presenting in Labor: A Cost-Effectiveness Analysis. Poster presented by Dr. Doyle at the 2005 Society for Maternal-Fetal Medicine annual meeting, Reno, Nevada, February 7-12, 2005.

Tung, C., Sangi-Haghpeykar, H. and **Levison, J**. A comparison of prenatal rapid HIV testing to HIV ELISA testing in a low socioeconomic population (submitted for publication). Presented at

Ob/Gyn Resident Research Day (by Dr. Tung), May 2006 (first place among 12 Baylor Ob/Gyn resident projects)
Harris County Hospital District Quality Assurance Committee (by Dr. Levison), June 2006
*****Texas Association of Obstetricians and Gynecologists Resident Research Day (by Dr. Tung), May 2007 (second place in the state of Texas)

Beasley, A.,Sangi-Haghpeykar, H., Giordano, T. and **Levison, J.** HIV Perinatal Data Base. Presented at Ob/Gyn Resident Research Day, May 2007

Beard, L., **Levison, J.**, Ramin, S. and Berens, P. Assessment of provider knowledge regarding HIV and pregnancy , prior to and following initiation of rapid HIV testing hospital protocol. Presented (by Dr. Beard) June 23, 2007 at University of Texas Ob/Gyn Resident Research Day.

Mendiola, M., Aziz, N., Sokoloff, A., Cohan, D., and **Levison, J**. Days to viral load suppression in naïve and experienced pregnant HIV patients treated with highly active antiretroviral therapy. Presented at Ob/Gyn Resident Research Day, May 2009 (third place out of 12 Baylor Ob/Gyn residents)
*****Texas Association of Obstetricians and Gynecologists Resident Research Day (by Dr. Mendiola), May 2010 (second place in the state of Texas).

Coleman, A., **Levison, J**., Sangi-Haghpeykar, H., and Ankobea, F. Knowledge, attitudes, and practices regarding human papilloma virus vaccination in Ghana, West Africa. Presented at Ob/Gyn Resident Research Day, May 2010 (tied for third place among 12 Baylor Ob/Gyn residents).

*Pratts, M., Sangi-Haghpeykar, H., Parkerson, G.R., and **Levison, J.** Single-visit "See-and-Treat" cervical cancer screening project in rural Honduras. Poster for ACOG District Meeting, October 18, 2010, Maui, Hawaii.

*Siddiqui, R., **Levison, J**., Sangi-Haghpeykar, H., and Bell, T. Predictive factors for loss to postpartum follow-up in HIV-positive women in Harris Country Hospital District. Poster for 2012 CFAR (Center for AIDS Research) Joint Symposium on HIV Research in Women, September 19, 2012, Providence, Rhode Island.

***Levison, J**., Nanthuru, D., Chiudzu, G., Kazembe, P., Phiri, H., and Aagaard, K. Utility of qualitative research for assessment of attitudes and knowledge on preterm birth in a low resource setting. Poster at Society for Maternal Fetal Medicine, February 14-16, 2013, San Francisco, California.

*Rahangdale, L., Cohen, S., Stewart, R., **Levison, J**., Lazenby, G., Baddell, M. et al. Predictors of unplanned pregnancies among women living with HIV in the United States. Poster at 20th Conference on HIV and Opportunistic Infections (CROI), March 3-6, 2013, Atlanta, Georgia.

*Adamski, A., Clark, R.A., Mena, L., Henderson,H., **Levison, J**., Schmidt, N., Martin, D.H., and Kissinger, P. The influence of ART on the treatment of *Trichomonas vaginalis* among HIV-infected women. Poster presentation at the Society for Pediatric and Perinatal Epidemiologic Research, June 17-18, 2013, Boston, Massachusetts.

*Acacia Cognata, MD, MSPH, Rebecca Hoban, MD, MPH, Maame Aba Coleman, MD, **Judy Levison, MD, MPH**, Kjersti Aagaard, MD., Ph.D., Alina Saldarriaga, MD and Elizabeth Montgomery, MD, MPH. Knowledge, Skills, and Use of Neonatal Resuscitation in Malawi, Before and After Participation in a Helping Babies Breath Train the Trainer Program. Poster at American Academy of Pediatrics, October 26-29, 2013.

*Acacia Cognata, MD, MSPH, Rebecca Hoban, MD, MPH, Jennifer Ann Werdenberg, MD, Alina Saldarriaga, MD, Asad Moten, BS, Kjersti Aagaard, MD., Ph.D., Maame Aba Coleman, MD, **Judy Levison, MD, MPH**, Nicole Salazar-Austin, MD, Norma Perez, DO, Sarah Perry, MD, Lineo Thahane, MD, MPH, Marape Marape, MD, Gabriel Anabwani, MB.Ch.B., Edith Mohapi, MBBS, FAAP and Elizabeth Montgomery, MD, MPH Knowledge and Skill Acquisition After "Helping Babies Breathe" Training in Sub-Saharan Africa: A 4 Country Experience. Poster at American Academy of Pediatrics, October 26-29, 2013.

*Elizabeth Montgomery Collins, Acacia Cognata, Rebecca Hoban, Asad Moten, Sarah Perry, Nicole Salazar-Austin, Alina Saldarriaga, Norma Perez, Marape Marape, Mogomotsi Matshaba, Lineo Thahane, Edith Mohapi, Peter Kazembe, Jennifer Werdenberg, Linda Malilo, Hailu N Sarero, Dipesalema Joel, Grace Karugaba, **Judy Levison**, Kjersti Aagaard, Aba Coleman, Gabriel Anabwani. Neonatal Resuscitation Knowledge & Skill Acquisition, Retention, & Use in Botswana, Lesotho, Malawi, & Swaziland Before & After Participation In a Helping Babies Breathe Train-the-Trainer Program. AAP National Conference & Exhibition, Section on International Child Health, Global Child Health Abstract Symposium, October 28, 2013, Orlando, FL.

*Williams, N., Peters, Y., Green, M., Deverson, C., and **Levison, J**. Postpartum Retention in Care Among Women with HIV. Poster at 2014 Texas HIV-STD Conference, August 19-21, Austin, TX.

*Fastring, D., Amedee, A., Gatski, M., Clark, R.A., Mena, L., **Levison, J**., Schmidt, N., Gustat, J., Hassig, S., and Kissinger, P. Heavy Alcohol Consumption and Vaginal Shedding of HIV. Poster at American Public Health Association, November 15-19, 2014, New Orleans, LA.

Levison, J., Smith, H., and Eppes, C. Innovations in Retention in Care after Delivery: CenteringPregnancy. Presented at the Elimination of Mother to Child Transmission Stakeholders annual meeting (sponsored by CDC and ACOG), July 27, 2016, Washington, DC.

*Stewart, K., Allen, S., Chesnokova, A., Syed, F., and **Levison, J.** Prevalence of Abnormal Cervical and Vaginal Cytology in HIV-Infected Women over the Age of 65. Poster at Annual Clinical Meeting, American College of Obstetricians and Gynecologists, April 27-10 2018, Austin, TX.

*Bowden, E., Dorland, J., Hawkins, J., Hickerson, L., and **Levison, J**. Outcomes of Breastfeeding Among HIV-Exposed Infants in Houston, Texas. Poster at Annual Meeting of American College of Obstetricians and Gynecologists Districts IV, VII, and XI, September 27-29 2019, New Orleans, LA.

***International**:*
***Levison, J.** Perinatal transmission of HIV and vaginal delivery: the Houston experience. Lecture to German Austrian AIDS Congress, Frankfurt, Germany. Presented June 30, 2007.

*Kissinger, P., Mena, L., **Levison, J.**, Clark, R.A., Henderson, H., Rosenthal, S., Schmidt, N., Reilly, K., Gatski, M., Barnes, T., Thomas, A., and Martin, D. Adherence to patient delivered partner treatment by HIV-infected women with Trichomonas vaginalis. Poster presented at the 18th International Society for Sexually Transmitted Diseases Research, June 28-30, 2009, London, England.

*Williams, N., Peters, Y., Green, M., Deverson, C., and **Levison, J**. Postpartum Retention in Care Among Women with HIV. Poster at the Ninth InternationalConference on HIV and Prevention, June 8-10, 2014, Miami, FL.

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B. Publications

1. ***Full papers***

a. published in peer review journals

1) Doyle, N., **Levison, J.**, and Gardner, M. Rapid HIV versus enzyme-linked immunosorbent assay screening in a low-risk Mexican American population presenting in labor: A cost-effectiveness analysis. American Journal of Obstetrics and Gynecology (2005), 193:1280-5.

2) Levison, J. The ostrich syndrome: Obstetrician-gynecologists and human immunodeficiency virus exposure. Obstetrics and Gynecology (2008), 111(1):183-186.

3) Arya, M., **Levison, J**., and Giordano, T.P. Ongoing barriers to HIV testing during pregnancy: A need for media campaigns addressing low knowledge about

perinatal HIV transmission among women in the United States. Letter to the editor, AIDS Patient Care and STDs (2010), 25(2):71-2.

4) Tung, C., Sangi-Haghpeykar, H. and **Levison, J**. A comparison of prenatal rapid HIV testing to HIV ELISA testing in a low socioeconomic population. Journal of Perinatology (2010), 30:30-32.

5) Levison, J., Williams, L., Moore, A., McFarlane, J., and Davila, J. Increasing Use of Rapid HIV Testing in Labor and Delivery Among Women with No Prenatal Care: A Local Initiative. Maternal and Child Health Journal (2010), 16(9):1748-1753.

6) Kissinger, P., Mena, L., **Levison, J**., Clark, R. A., Gatski, M., Henderson, H., Schmidt, N., Rosenthal, S., Myers, L., and Martin, D. A randomized treatment trial: Single versus 7 day dose of metronidazole for the treatment of Trichomonas vaginalis among HIV-infected women. Journal of Acquired Immune Deficiency Syndromes (2010), 55(5):565-571.

7) Gatski, M., Mena, L., **Levison, J.**, Clark, R., Henderson, H., Schmidt, N., Rosenthal, S., Martin, D., and Kissinger, P. Patient-delivered treatment and Trichomonas vaginalis repeat infection among HIV-infected women. Sexually Transmitted Disease (2010), 37(8):502-5.

8) Levison, J., Gillespie, S., and Montgomery, E. Think twice before recommending pre-masticated food as a source of infant nutrition. Maternal and Child Nutrition (2011), 7, 104.

9) Kissinger, P., Mena, L., **Levison, J**., Clark, R. A., Gatski, M., Henderson, H., Schmidt, N., Rosenthal, S., Myers, L., and Martin, D. The influence of bacterial vaginosis on the response to Trichomonas vaginalis treatment among HIV-infected women. Sexually Transmitted Infections (2011), 87(3):205-208.

10) Coleman, M.A., **Levison, J.**, and Sangi-Haghpeykar, H. HPV vaccine acceptability in Ghana, West Africa. Vaccine (2011) May 23. 29(23):3945-3950.

11) Levison, J., Williams, L., Moore, A. McFarlane, J., and Davila, J. Educating professionals in obstetrics and gynecology regarding rapid human immunodeficiency virus (HIV) testing in labor and delivery: A local initiative. Maternal and Child Health Journal (2012), 16(9), 1748-1753.

12) Robicheaux McKinney, J., Halpern, M., **Levison, J**., Callender, G., Lerebours-Nadal, L., and Fernandez-Esquer, M.E. Factors influencing use of family planning services among HIV-positive women in the PMTCT program at Clinica Familia La Romana in the Dominican Republic. Sexuality and Research (2013), 10(3):200-207.

13) Nacius, L., **Levison, J**., Minard, C., Spence, L., and Davila, J. Serodiscordance and disclosure Among HIV-Positive Pregnant Women. AIDS Patient Care and STDs (2013), 27(4):242-7.

14) Kissinger, P., Adamski, A., Clark, R., Mena, L., **Levison, J**., and Martin, D. Does antiretroviral therapy interfere with the treatment of Trichomonas vaginalis among HIV+ women? Sexually Transmitted Diseases (2013), 40(6):506-7.

15) Aziz, N., Leva, N.V., Sokoloff, A., Mendiola, M.L., **Levison, J**., Feakins, C., Shannon, M., and Cohan, D. Time to viral suppression in antiretroviral-naïve and –experienced pregnant women on highly active antiretroviral therapy: implications for pregnant women presenting late in gestation. British Journal of Obstetrics and Gynecology (2013), 120(12):1534-47.

16) Levison, J. Reproductive health and preconception care for women and men: What HIV providers should know. HIV Specialist/ American Academy of HIV Specialists (2013), 5(4):37-39.

17) Fastring, D., Amedee, A., Gatski, M., Clark, R., Mena, L., **Levison, J.**, Schmidt, N., Rice, J., Gustat, J., and Kissinger, P. Co-occurrence of Trichomonas vaginalis, and bacterial vaginosis and vaginal shedding of HIV-1 RNA. Sexually Transmitted Diseases (2014), 41(3):173-9.

18) Rahangdale, L., Stewart, A., Stewart, R.D., Badell, M., **Levison, J**., et al. Pregnancy intention among women living with HIV in the United States. Journal of Acquired Immunodeficiency Syndromes (2014), 65(3):306-11.

19) Siddiqui, R., Bell, T., Sangi-Haghpeykar, H., Minard, C., and **Levison, J**. Predictive factors for loss to postpartum follow-up among low income HIV-infected women in Texas. AIDS Patient Care and STDs (2014), 28(5):248-253.

20) Levison, J., Nanthuru, D., Chiudzu, G., Kazembe, P., Phiri, H., Ramin, S., and Aagaard, K. Qualitative assessment of attitudes and knowledge on preterm birth in Malawi and within country framework of care. BMC Pregnancy and Childbirth (2014), 14:123.

21) Levison, J., Weber, S., and Cohan, D. Breastfeeding and human immunodeficiency virus-positive women in the United States: Harm reduction counseling strategies. Clinical Infectious Diseases (2014). 59(2):304-309.

22) Adamski, A., Clark, R., Mena, L., Henderson, H., **Levison, J.**, Schmidt, N., Gebrekristos, H., Martin, D., and Kissinger. The influence of ART on the treatment of Trichomonas vaginalis among HIV-infected women. Clinical Infectious Diseases (2014), 59(6):883-887.

23) Buzi, R. and **Levison, J**. Missed opportunities: HIV in Houston. Baylor College of Medicine Office of Communications newsletter. September 15, 2014.

24) Levison, J., Weber, S. and Cohan, D. Reply to Kennedy, et al. Clinical Infectious Diseases 2014; doi: 10.1093/cid/ciu855

25) Buchberg, M, Fletcher, F., Vidrine, D., **Levison, J**., Peters, M., Hardwicke, R., Yu, X., and Bell, T. A mixed-methods approach to understanding barriers to postpartum retention in care among low-income, HIV-infected women. AIDS Patient Care and STDs (2015), 29(3),1-7.

26) Dominika Seidman, Theodore Ruel, Lisa Rahangdale, Pooja Mittal, Christine Pecci, Shannon Weber, Ronald Goldschmidt, Deborah Cohan, **Judy Levison**. A clinical approach to elimination of perinatal HIV transmission in resource-richsettings. International Journal of Gynecology and Obstetrics (2015), 131(3), 309-310.

27) Kahr, M., Padgett, S., Shope, C., Griffin, E., Xie, S.S., Gonzalez, P.J., **Levison, J.,** Mastrobattista, J., Abramovici, A.R., Northrup, T.F., Stotts, A.L., Aagaard, K., and Suter, M.A. A qualitative assessment of the perceived risks of electronic cigarette and hookah use in pregnancy. BMC Public Health 2015. 15: 1273.

28) Antony, K., Harris, R.A., **Levison, J.**, Banda, B., Chiudzu, G., Chirwa, R., Nyondo, M., Marko, E., Chigano, A., Ramin, S., Phiri, H., Raine, S., Belfort, M,. Kazembe, P., and Aagaard. K. Population-based estimation of the peridontal disease rate in Malawi and compliance with preventive/treatment measures. AJOG (2016). 214(1): S295-6.

29) Finocchario-Kessler, S., Champassak, S., Hoyt, M.J., Short, W., Chakraborty, R., Weber, S, **Levison, J**., Phillips, J., Storm, D., and Anderson, J. Pre-Exposure Prophylaxis (PrEP) for Safer Conception Among Serodifferent Couples: Findings from Healthcare Providers Serving Patients with HIV in Seven US Cities. AIDS Patient Care and STDs (2016), 30(2), 78-83.

30) Lisa Rahangdale, MD, MPH, Jordan Cates, MSPH, JoNell Potter, PhD, Martina L. Badell, MD, Dominika Seidman, MD, Emilly S. Miller, MD, MPH, Jenell S. Coleman, MD, MPH, Gweneth B. Lazenby, MD, MSCR, **Judy Levison**, MD, William R. Short, MD, MPH, Sigal Yawetz, MD, Andrea Ciaranello, MD, MPH, Elizabeth Livingston, MD, Lunthita Duthely, EdD, MS, Bassam H. Rimawi, MD, Jean R. Anderson, MD, Elizabeth M. Stringer, MD, HOPES (HIV OB Pregnancy Education Study) Group. Integrase inhibitors in late pregnancy and rapid HIV viral load reduction. AJOG (2016), 214(3): 385.e1-385.e7.

31) Smeltzer, S., Yu, X., Schmeler, K., and **Levison, J**. Abnormal vaginal Pap test results after hysterectomy in human immunodeficiency virus–infected women. Obstetrics and Gynecology (2016), 158(1), 52-57.

32) Johnson, G, **Levison, J**, and Malek, J. Should providers discuss breastfeeding with women living with HIV in high-income countries? An ethical analysis. Clinical Infectious Diseases (2016), 63(10), 1368-1372.

33) **Levison, J**. Editorial: Safe sex includes knowing your partner's HIV status. Journal of Perinatology (2017), 37, 1.

34) Pollack, L. and **Levison, J.** Role of preexposure prophylaxis in the reproductive health of women at risk for human immunodeficiency virus infection. Obstetrics and Gynecology (2018), 132(3), 687-691.

35) Antony, K., **Levison, J.**, Suter, M., Raine, S., Chiudzu, G. Phiri, H., Sclafani, J., Belfort, M., Kazembe, P., and Aagaard, K. Qualitative assessment of knowledge transfer regarding preterm birth in Malawi following the implementation of targeted health messages over 3 years. International Journal of Women's Health (2019), 11, 75-95.

36) Badell, M., Sheth, A., Momplaisir, F., Rahangdale, L., Potter, J., Woodham, P., Lazenby, G., Short, W., Gillespie, S., Balreldrin, N., Miller, E., Alleyne, G., Duthely, L., Allen, S., **Levison, J**. and Chakraborty, R. A multicenter analysis of elvitegravir use during pregnancy on HIV viral suppression and perinatal outcomes. Open Forum Infectious Diseases (2019), 6(4), ofz129.

37) **Levison, J.** and Pollock, L. Letter to the Editor: Pediatric care of HIV-exposed breastfeeding infants. Journal of Pediatric Infectious Diseases (2019).

Accepted or in press:

2. ***Other full papers***

a. published without review by peer group

Levison, J. Prevention of Perinatal Transmission of HIV in 2008. Research Initiative/ Treatment Action (2008), 13(2), 41-46.

b. in preparation

3. ***Abstracts:*** none
4. ***Books****:* none
5. ***Other works communicating research results to scientific colleagues***:
6. ***Other works communicating research results to general public***

HIV and pregnancy. Houston Chronicle 1-18-07.

Rapid HIV testing. KUHF Houston public radio 3-9-07.
http://www.kuhf.org/site/News2?page=NewsArticle&id=19620

III. TEACHING INFORMATION

A. Didactic course work

BCM

2000-present
Lectures on topics including abnormal Paps, contraception, infertility, and abnormal uterine bleeding to Family Medicine residents (minimum of two per year)

2003- present Annual lecture
Women's Health section of International Health, BCM International Health track class (two to three hour seminar for 40-50 second year medical students)

2007-present Annual lecture
Women's Issues in International Health (focus on obstetric fistula, female genital cutting and HIV). BCM International Health track (one hour lecture to 30-40 first year medical students)

2012-present Semi-annual lecture
Gynecologic and Obstetric Care of Women Living with HIV in Low Resource Settings. BCM National School of Tropical Medicine.

2013 and 2014 Women's Health: A Focus on Female Genital Cutting. BCM first year medical school women's health elective.

University of Texas School of Public Health

2005-2008 Lecture on prevention of perinatal HIV transmission to Dr. Richard Grimes' Masters in Public Health class
2012 Lecture on HIV and women to Dr. Sheryl McCurdy's PhD class on global issues related to HIV

B. Non-didactic teaching

1. ***Resident teaching***

2001-present
Precept Family Medicine residents in consultative Ob/Gyn and HIV-associated Ob/Gyn as part of their two month Women's Health rotation (20-26 hours/week)

2005-2010
Precept Obstetric and Gynecology residents in consultative Ob/Gyn and HIV-related Ob/Gyn as part of an elective in HIV Ob/Gyn (20 hours/week about 6 months per year)

2003-2011
Precept pediatric residents on infectious disease rotation in prenatal HIV clinic (about 12 half day sessions per year)

Resident mentoring: Ob/Gyn resident research projects (see research information above)

Celestine Tung 2006
Anitra Beasley 2007
Monica Mendiola 2008-9
Aba Coleman 2009-10
Amy Kung 2009-11
Robaab Siddiqui 2010-2011
Karen Sargent 2012-2014
Stephanie Smeltzer 2013-2016
Chioma Erondu 2016-2017
Emily Bowman 2018-2019

Physician assistant mentoring: Research project
Lori Nacius 2010-2011
Scott Braddock 2015-2016

2. ***Clinical fellow training***
2003-2011
Precept pediatric infectious disease fellows on retrovirology rotation in prenatal HIV clinic (about 4-6 half day sessions/year)
2015-present
Precept maternal fetal medicine fellow in prenatal HIV clinic (1-2 weeks/year)

3. ***Research fellow training***:
2017-present
Post-doc research coordinator who coordinated multiple clinical research projects

4. ***Graduate student training***
--Have had eight to ten visiting physicians and nurses from Lesotho, Swaziland, Botswana, and The Netherlands attend my HIV clinics (up to 12 hours/week each for 4-6 weeks during 2003-2006)
--Precepted Aitebureme Aigbe, DrPH candidate in at UT School of Public Health 2012-2014
--Multiple MPH students 2014-2018

5. ***Medical student mentoring***
Lee Bar-Eli MS3 2006-7: precepted in clinic and supported her in obtaining Fogarty fellowship for international experience in Lesotho (scheduled for 2008)

Jennifer M. Lopez MS3 2007-8: precepted in clinic and supervised her on trip to La Romana, Dominican Republic 7-08

Jennifer Robicheaux McKinney/ Class of 2014: precepted in clinic, was mentor from 2000-2014, co-authored study on contraception among HIV-positive teens

2009-present
Precept medical student on core ob/gyn rotation one half day per week year round

2010-2016
Precept third year medical student on LACE rotation one half day per month year round

2013-2016
Precept first year medical student in PPS course one half day every two-three weeks year round

2016-present
Precept second year physician assistant students 1-3 days per month

6. Curriculum development

2002-present
Developed reading list for two month Family Medicine residency Women's Health rotation and one month Ob/Gyn elective in a community health center

2007-2012
Liaison between BCM Dept of Ob/Gyn and resident/medical student elective in La Romana, Dominican Republic. With Columbia University on site physician, annually revamp schedule for visiting student or resident experience in outpatient HIV clinic, public hospital, and private clinic (average of 2 per year)

2010-2011
Worked with Family Medicine, Internal Medicine, and Emergency Department faculty and 6-8 medical students in the International Track to restructure the second year International Track curriculum. Recruited two professors from the University of Texas School of Public Health to present information on development of public health interventions as well as methods to monitor and assess interventions; they are now an integral part of the program.

2012-present
Development of online tool to educate clinicians, nurses, and social workers about diagnosis/management of HIV in pregnancy/in labor, management of the HIV-exposed newborn, routine HIV screening in a gynecology practice, and prevention of congenital syphilis (2 hours CME and CNE for physicians, nurses, and social workers). Perinatal HIV Prevention. Course #1029521. https://tx.train.org

C. Lectures

1. ***International***

Practical Management of HIV in Pregnancy. Mbabane, Swaziland. March 2004.

Frankfurt, Germany. Perinatal transmission of HIV and vaginal delivery: the Houston experience. German Austrian AIDS Congress. June 30, 2007.

Katmandu, Nepal. Prevention of Mother to Child HIV Transmission/Training of Trainers. UNICEF/Baylor International Pediatric AIDS Initiative. June 21-25, 2010.

Levison, J., Aagaard, K., and Antony, K. Saving Lives at Birth: Being Born Too Soon. March of Dimes-sponsored lecture to clinical officers, nurses, and health workers at the Baylor-Malawi Center for Excellence, Lilongwe, Malawi. May 9, 2015.

Levison, J., Aagaard, K., and Antony, K. HIV, Pregnancy, and Preterm Birth. March of Dimes-sponsored lecture to clinical officers, nurses, and health workers at the Baylor-Malawi Center for Excellence, Lilongwe, Malawi. May 9. 2015.

Levison, J. HIV and Women: A Global Challenge. Lecture to physicians, clinical officers, and nurses at the Ethel Mutharika Maternity Wing, Kamuzu Central Hospital, Lilongwe, Malawi, January 23, 2016.

Smith, H, Eppes, C, Peters, Y, Deverson, C, Davis, V, and **Levison, J.** et al. Poster: Impact of Group Prenatal Care on Postpartum Retention in Care Among Women Living with HIV. Seventh International Workshop on HIV and Women. Seattle, WA, February 11-12, 2017.

Levison, J, Pollock, L and Friedman, N. Disclosure of HIV Status to Partners**.** Seminar for practitioners attending Conference for Retroviruses and Opportunistic Infections. Seattle, WA, February 15, 2017.

Pollock, L., **Levison, J.**, and Matthews, L. Does U = U in the Perinatal Setting? Seminar for practitioners attending Conference for Retroviruses and Opportunistic Infections (CROI). Boston, MA, March 6, 2018.

Dilemmas in the Choice of Antiretroviral Therapy in Women. Roundtable hosted by the Clinicians Consultation Center, Conference for Retroviruses and Opportunistic Infections. Seattle, WA, March 5, 2019.

2. ***National***

Annual Northwest Obstetrics and Gynecology Conference. HIV in Pregnancy. Everett, Washington, April 1, 2004.

Annual Northwest Obstetrics and Gynecology Conference. Metabolic Syndrome and Ob/Gyn. Everett, Washington, April 1, 2004.

Grand Rounds presentation to the Department of Obstetrics and Gynecology, Santa Clara Valley Medical Center, San Jose, California. HIV in Pregnancy: Prevention of Perinatal Transmission. April 2005.

Santa Clara Valley Medical Center, San Jose, California. International Challenges: Prevention of Perinatal HIV Transmission. April 2005.

IV Cumbre de Educadores de Tratamientos del VIH/SIDA. Prevencion de la Transmision Perinatal de VIH. Houston, Texas, June 19, 2008 (presented in Spanish).

Centers for Disease Control, invited panelist, for campaign to edúcate gynecologists about routine HIV screening. Atlanta, Georgia, March 25, 2009.

Office of Family Planning/Office of Population Affairs HIV Prevention Project Annual Technical Support Conference. Reproductive health needs of HIV-positive women. New Orleans, Louisiana, March 16, 2011.

2012 Federal Training Centers Collaboration Meeting. Preconception and Reproductive Health for Women and Men Living with HIV. Dallas, Texas, April 24-26, 2012.

Reproductive Health and HIV: Preconception Care, Family Planning, and Safer Conception. Teleconference sponsored by FXB Center at UMDNJ, Drexel University, Jefferson School of Medicine, and Baylor College of Medicine and supported by Centers for Disease Control. May 15, 2012.

2012 Elimination of Mother-to-Child HIV Transmission Stakeholders' Meeting. Invited speaker on breastfeeding among HIV-positive women in the United States. Sponsored by FXB Center, Centers for Disease Control, and Health Research and Educational Trust (HRET). Washington, D.C. September 13, 2012.

2013 American Conference for the Treatment of HIV (ACTHIV) annual conference. Invited speaker on Preconception Care, Contraception, and Safer Conception for Women, Men, and Couples Living with HIV. Denver, Colorado, March 21-23, 2013.

2014 HIV/STD Update: Advances in Care and Prevention. Invited speaker on Reproductive Health and HIV. Sponsored by Midwest AIDS Training and Education Center. Indianapolis, Indiana, May 9, 2014.

2014 What Is New in the Perinatal Guidelines? Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Prevent Perinatal HIV Transmission in the United States. CDC's Elimination of Mother-to-Child (EMCT) Stakeholders Group, in collaboration with the François-Xavier Bagnoud (FXB) Center and AETC National Resource Center. National webinar, May 20, 2014.

Introduction to CenteringPregnancy/HIV. Presentation at CDC-sponsored Elimination of Maternal Child Transmission of HIV Panel. Washington, DC, May 29, 2014.

New Frontiers in Safe Sex. National Hemophilia Foundation Annual Meeting, Grapevine TX, August 15, 2015.

Retention in Care After Delivery among Women Living with HIV: Innovation Approaches. Elimination of Mother to Child Transmission Stakeholders Group. Washington, DC, July 28, 2016.

Pre-Exposure Prophylaxis: What Obstetricians and Gynecologists Need to Know. With Carey Eppes, MD and Kevin Ault, MD. Webinar sponsored by the American College of Obstetricians and Gynecologists and CDC's Expert Panel on HIV Reproductive Health and Preconception Care, October 26, 2016.

Update in Perinatal Guidelines 2016. Presentation to the Clinicians Consultation Center with Lisa Rahangdale. University of California San Francisco, November 9, 2016.

What is New in the 2016 Perinatal HIV Treatment Guidelines? With Lisa Rahangdale. National webinar sponsored by the Elimination of Mother to Child Transmission Stakeholders Group, December 7, 2016.

HIV and Women. AIDS Clinical Conference series. University of Washington, Seattle, April 18, 2017.

Post-exposure Prophylaxis in Women/New Frontiers in Safe Sex. Women and HIV International Clinical Conference (WHICC). San Antonio, TX, June 11-12, 2017.

Update on Women Living with HIV. Presented to Project LEAP (HIV community leadership training), sponsored by the Ryan White Program at the Harris County Public Health and Environmental Services, June 17, 2017.

CenteringPregnancy: Adapted for Women Living with HIV. National webinar sponsored by the Centering Health Institute (Boston), October 10, 2017.

The Controversy Surrounding Breastfeeding among Women Living with HIV in High Resource Countries. Mountain West AIDS Education and Training Center webinar, November 2, 2017.

Pregnancy Management and HIV. Southeast AIDS Education and Training Center webinar, January 10, 2018.

What is New in the Guidelines November 2017. Clinicians Consultation Center, webinar for University of California San Francisco clinical staff, January 24, 2018.

Update in the Perinatal Guidelines. National webinar, February 27, 2018.

Reproductive Decision Making, Sexual Health, and HIV. Presentation at ACT HIV, Chicago, IL, April 24, 2018.

Innovations in Prenatal Care of Women Living with HIV. Presentation at CityMatch, Portland, OR, September 12, 2018.

Evaluation of HIV-Adapted CenteringPregnancy Group Prenatal Care Among Women Living with HIV in Houston, Texas. Poster at the Society for Maternal Fetal Medicine, Las Vegas, NV, February 15, 2019.

Approaching HIV Epidemic from a Reproductive Justice Framework. 2019 Washington State HIV Conference. Spokane, WA, May 17, 2019.

Management of Pregnancy for Women Living with HIV. Mid-Atlantic States AIDS Education Center Training webinar. May 22, 2019.

Evaluation of HIV-Adapted CenteringPregnancy Group Prenatal Care Among Women Living with HIV in Houston, Texas. Oral presentation by Jennifer McKinney, Infectious Disease Society of Obstetrics and Gynecology, Big Sky, MT, August 8, 2019.

3. ***Regional***

Women and HIV International Clinical Conference. Office Gynecology and the HIV+ Woman. San Antonio, Texas, March 7, 2007.

Panelist and facilitator for CDC workshop. Implementation of HIV Screening in Acute Care Settings. San Antonio, Texas, February 25-26, 2008.

16th Texas HIV/STD Conference. HIV Perinatal Transmission Prevention Projects in Texas—presented in collaboration with Jenny McFarlane from the Texas Department of State Health Services, Austin, Texas, May 19, 2008.

Women and HIV International Clinical Conference (WHICC). Office Gynecology and the HIV+ Woman. Dallas, Texas, April 30, 2008.

AIDS Education Training Center conference. Rapid HIV Testing in Labor and Delivery…and Beyond. Amarillo, Texas, June, 2008.

Triangle AIDS Network 21st AIDS Update Conference. Prevention of Perinatal HIV. Beaumont, Texas, October 13, 2008.

Valley AIDS Council 16th Annual HIV-AIDS Update Conference. Rapid Testing in Labor and Delivery. South Padre Island, Texas, October 30, 2008.

Kaleidoscope: 26th Annual Perinatal Nursing Symposium. Rapid HIV Testing in Labor… and Beyond. Galveston, Texas, February18, 2009.

Triangle AIDS Network CME for physicians, nurses and social workers. Rapid HIV Testing in Labor and Delivery. Beaumont, Texas, March 17, 2009.

St. David's Hospital CEU for nurses, social workers. Rapid HIV Testing in Labor and Delivery…and Beyond. Round Rock, Texas May 21, 2009.

Valley Baptist Hospital Harlingen CEU for nurses, social workers. Rapid HIV Testing in Labor and Delivery…and Beyond. Harlingen, Texas July 23, 2009.

St Luke's Baptist Hospital CEU for nurses, social workers. Rapid HIV Testing in Labor and Delivery…and Beyond. San Antonio, Texas, September 3, 2009.

Rio Grande Valley Perinatal Symposium Rapid HIV Testing in Labor and Delivery. Harlingen, Texas , November 7, 2009.

Women and HIV International Clinical Conference (WHICC). Panelist – Update on HIV Testing of Pregnant Women. Houston, Texas, January 25, 2010.

17th Texas HIV/STD Conference. The Journey to Change Texas HIV Testing of Pregnant Women. Austin, TX May 25, 2010

Update on Texas HIV Testing Requirements for Pregnant Women:
2-19-10 St. Joseph Medical Center, Houston
4-9-10 HIV Update Conference, Panhandle AIDS Support Organization (PASO), Amarillo
4-26-10 Beaumont Baptist Hospital, Beaumont
6-29-10 Cypress Fairbanks Hospital, Houston
7-1-10 Christus-St. Elizabeth Hospital, Beaumont
11-23-10 Nagadoches Medical Center, Nacogdoches

Jasper-Newton County Medical Society. Reproductive Health Needs of HIV-Positive Women/Routine HIV Testing. Jasper, Texas, October 17, 2012.

Amarillo Area HIV/STDs Symposium 2013. Reproductive Health Needs of HIV-Positive Women. Amarillo, Texas, April 12, 2013.

American College of Obstetricians and Gynecologists District 11/Texas Association of Obstetricians and Gynecologists (TAOG). Update on STDs. San Antonio, Texas, September 28, 2013.

2014 Women and HIV International Clinical Care. Invited speaker on Reproductive Health and HIV: Reproductive Health: Preconception Care, Contraception and Safer Conception. Sponsored by Texas Oklahoma AIDS Education and Training Center. Webinar (Dallas, Texas), May 16, 2014.

Houston Global Health Consortium. Challenges to Developing Health Care Programs…Wherever You Are. Presented with Jennifer Robicheaux McKinney. Baylor College of Medicine, May 2014.

Women's Health Symposium. So You Have HIV and You Want to Have a Baby? Houston, TX, May 21, 2015.

PrEPHouston: HIV Prevention Summit. New Frontiers in Safe Sex including PrEPception. Presented in Houston, TX, February 5, 2016.

2018 Texas HIV/STD Conference. Sex, Reproductive Health, and HIV. Austin, TX, November 29, 2018.

Women and HIV 2019: Reproductive Decision Making and Sexual Health. University of Texas Medical Branch, Galveston, TX, March 14, 2019.

Abnormal Cervical Cytology in 2019: What Do I Do Next? Primary Care Update 2019. Baylor College of Medicine, Houston, TX, March 23, 2019.

4. ***Local***

Obstetrics and Gynecology Grand Rounds presentation. Baylor College of Medicine Prevention of Perinatal Transmission of HIV. January 29, 2003.

Obstetrics and Gynecology Resident Research Day, discussant of presentation on high false positive rate of ELISA testing in a predominantly Hispanic prenatal population (Zacharias, N.), May 2003.

Guest lecturer for Dr. Richard Grimes' course on HIV/AIDS, University of Texas School of Public Health. Women and HIV. September 29, 2003.

Obstetrics and Gynecology Grand Rounds presentation, Baylor College of Medicine. Women and HIV. February 25, 2004.

Infectious disease physicians and staff conference at Thomas Street Clinic, Houston, Texas. HIV in Swaziland. June 29, 2004.

Guest lecturer for Dr. Richard Grimes' course on HIV/AIDS, University of Texas School of Public Health. HIV in Pregnancy. September 28, 2004.

Obstetrics and Gynecology Grand Rounds presentation. Baylor College of Medicine. International Challenges: Prevention of HIV Transmission. January 19, 2005.

Guest lecturer for Dr. Richard Grimes' course on HIV/AIDS, University of Texas School of Public Health. Women and HIV. September 2005.

Guest lecturer for Dr. Richard Grimes' course on HIV/AIDS, University of Texas School of Public Health. Women and HIV. September 2006.

Harris County Hospital District Annual HIV conference, Houston, TX. International Challenges in HIV. December 2005.

2005-2008 Multiple talks to physicians and nurses on Rapid HIV testing in Labor and Delivery (part of research projects above) at Ben Taub General Hospital, BCM Department of Obstetrics and Gynecology residents lecture series, LBJ Hospital, Houston Perinatal Task Force—4 to 6 presentations per year

Global Coalition of UNAIDS, University of Texas School of Public Health. Prevention of Perinatal HIV Transmission. June 12, 2006.

Harris County Hospital District coders, LBJ Hospital, Houston, TX. Coding and Gynecology: What Does the Gynecologist Really Do? July 2006.

Baylor Pediatric AIDS Initiative (BIPAI) first Pediatric AIDS Corps (PAC) physicians orientation. Prevention of Perinatal HIV Transmission—in the U.S. and Beyond. July 2006.

Association of AIDS Nurses (ANAC), Houston, TX. Women and HIV. August, 2006.

Obstetrics and Gynecology Resident Research Day, discussant of presentation on factors influencing breastfeeding intentions among low income Hispanic women (Champion, S.), May 2007.

University of Texas School of Public Health. World AIDS Day. HIV and Pregnancy: What is Happening in Houston? December 1, 2008.

Infectious disease physicians and staff conference at Thomas Street Clinic, Houston, Texas. The Serodiscordant Couple. December 2, 2008.

Texas Children's Hospital Women's Services Nursing leadership. Update on Texas HIV Testing Requirements for Pregnant Women. Houston, TX. November 18, 2009.

Thomas Street Health Center – staff conference. Update on Texas HIV Testing Requirements for Pregnant Women. Houston, TX. December 3, 2009.

Obstetrics and Gynecology Grand Rounds presentation. Baylor College of Medicine Update on Texas HIV Testing Requirements for Pregnant Women. Houston, TX. February 10, 2010.

Harris County Hospital District/AIDS Education Training Center/Department of State Health Services. Fundamentals of HIV Treatment and Disease Management: Managing Special Populations. Houston, TX. September 10, 2011.

Obstetrics and Gynecology Grand Rounds presentation. Baylor College of Medicine. Reproductive Health and HIV. Houston, TX. October 10, 2012.

Houston Department of Health and Human Services/Center for AIDS Research. Why do women drop out of care after they have their babies? Community Scientific Forum. Houston, TX. April 22, 2014.

Rice University Department of Bioengineering class. Update on Challenges to Developing Health Care Programs…Wherever You Are. Houston, TX. September 16, 2014.

AIDS Research Forum. New Frontiers in Safe Sex: HIV, Serodiscordant Couples, and PrEPception. Baylor College of Medicine, Houston, TX, February 15, 2016.

What is New in HIV Testing. Lecture to Maternal Fetal Medicine fellows. Texas Childrens Hospital Pavilion for Women, Houston, November 4, 2016.

Innovations in Retention in Care Among Women Living with HIV. Lecture to Adolescent Medicine fellows. Texas Childrens Hospital, Houston, November 4, 2016.

New Frontiers in HIV: What Do Obstetrician/Gynecologists Really Need to Know? Department of Ob/Gyn Grand Rounds, Baylor College of Medicine, January 25, 2017.

HIV and Women: CROI 2017 Update. Thomas Street Health Center, Houston, TX, March 7, 2017.

Women and HIV. Project LEAP (community education program). Harris County Department of Health and Environmental Services, Houston, TX, June 21, 2017.

Women and HIV: 2018 Update from the Conference for Retroviruses and Opportunistic Infections, Thomas Street Health Center, Houston, TX, April 2, 2018.

Breastfeeding and HIV in the United States: A Reasonable or Unreasonable Option? Department of Neonatology, Texas Children's Hospital, Houston, TX March 15, 2019.

What Women Around the World Have Taught Me. National Perinatal Association Student Society. Baylor College of Medicine, Houston, TX, February 12, 2019.

Women and HIV: 2019 Update. Thomas Street Health Center, Houston, TX, April 30, 2019.

Going Beyond (what is expected of physicians). University of Houston, Faculty Senate Partnerships conference, Houston, TX, October 4, 2019.

D. Visiting professorships: none

IV. MEDICAL AND SERVICE INFORMATION

A. Patient care responsibilities at BCM

1. ***Department –wide***

Division of time:

- 50% direct patient care for HIV+ women at Thomas Street Clinic and Northwest Health Center including 24/7 on call for clients and personally attending the deliveries of Women's Program clients (at Ben Taub General Hospital and Texas Childrens Hospital Pavilion for Women). 15-20 patients per week seen as outpatients. 60-70 deliveries per year. Quality indicators include less than 1% transmission of HIV from mother to child and increase in annual Paps from 25% to 75% in HIV+ female population at Thomas Street Clinic.
- 20% direct patient care/Ob/Gyn consultative service for the Department of Family Medicine at Northwest Health Center. 20-35 patients per week.
- 10% Rapid HIV Testing education for professionals. Includes development of computer modules for education of physicians and nurses regarding HIV testing and prevention of perinatal HIV transmission and development of FIMR-HIV methodology for Texas to assess causes of cases of perinatal HIV transmission.
- Consultant for the University of California, San Francisco (UCSF) Clinicians Consultation Center (real time advising clinicians nationally on management of HIV in pregnancy)
- Other: supervision of Ob/Gyn residents on Labor and Delivery 3 times per month (7-12 deliveries per 14 hour shift) and in surgery once or twice per month (3-5 major and minor cases per session)
- Supervision of Family Medicine residents in clinic
- 2012-present Development of a CenteringPregnancy model tailored to the needs of HIV-positive pregnant women

2. ***Section or specialty***:

Development of global health initiative and research (Malawi) 10% time 2011 through 2017

B. Clinical lab responsibilities at BCM: none (though work closely with Harris Health Laboratory in the interpretation of equivocal HIV tests)

C. National education or voluntary health organization participation:

2006-present
Member, Doctors for Change (local advocacy group) www.doctorsforchange.org

April 2007
Participated in UT United We Serve volunteer day

2009-2011
President, Doctors for Change (local advocacy group) www.doctorsforchange.org

2012-present

Pro bono examinations for Tahirih Justice Center asylum seekers

2013 and 2014
Houston Refugee Center clinic health fair volunteer

2013-present
Member, Board of Directors, Doctors for Change (see above)

2017-present
Member, Advisory Board, Schweitzer Fellowship Foundation, which provides chosen students with leadership in community health project planning

D. Administrative assignments at BCM: Institutional Safety committee 2007- present

E. Other pertinent information

1985 – 1986
Chair, Department of Obstetrics and Gynecology
Providence General Hospital of Everett
Everett, Washington

1986 – 1995
Medical Director
Prenatal Care Center (providing care for low-income women)
General Hospital Medical Center of Everett
Everett, Washington

2003-present
Physician coordinator, Harris County Hospital District Women's Program**, providing obstetric and gynecologic care for women with HIV

2005-2008
Chair, Harris County Hospital District HIV OB Task Force

2007-present
Chair, Perinatal Task Force (public and private hospital consortium with primary focus on bringing rapid HIV testing to Labor and Delivery and educating clinicians statewide)

2008-present
Member, Texas Consortium for Perinatal HIV Transmission—affiliate of Department of State Health Services/Division of HIV/STD—developed guidelines for legislation passed 6-5-09 and enacted 1-1-10 regarding timing of HIV testing in pregnancy
http://www aidseducation org/documents/PerinatalHIVGuidelines pdf

2013-present

Initiator/PI of CenteringPregnancy/HIV: first in the U.S. group prenatal care program for HIV-positive pregnant women. Part of a research study to assess 1) changes in knowledge/attitudes toward HIV and 2) retention in care one year postpartum. We predict higher fund of knowledge, more positive self-image, and higher rate of retention in care one year postpartum after group intervention (compared to controls).

**The Harris Health System Women's Program offers:

- Prenatal care for HIV+ women
- A unique collaboration between BCM and UT Health Science Center
- A multidisciplinary team approach to care involving physicians, nurses, nurse practitioner, nurse educator, social worker, and case managers with weekly review of ongoing clients
- Personalized care for a vulnerable population
- Resident and medical student opportunities for clinical rotations and research

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE; *et al.*,	)	
Plaintiffs,	)	CASE NO. 1:20-cv-323-LY
v.	)	
GREG ABBOTT, in his official capacity as Governor; *et al.*,	)	
Defendants.	)	

DECLARATION OF GEORGE A. MACONES, M.D., M.S.C.E., IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

GEORGE A. MACONES, M.D., M.S.C.E., hereby declares under penalty of perjury that the following statements are true and correct:

1. I am an obstetrician-gynecologist ("OB/GYN") specializing in maternal-fetal medicine ("MFM"). I currently serve as Chair of the Department of Women's Health at Dell Medical School at the University of Texas at Austin.

2. I earned an M.D. from Jefferson Medical College in Philadelphia, Pennsylvania, and a Master of Science in Clinical Epidemiology from the University of Pennsylvania. I completed a residency in obstetrics and gynecology at Pennsylvania Hospital and fellowships in MFM and clinical epidemiology at Thomas Jefferson Hospital and the University of Pennsylvania, respectively.

3. I am board certified by the American Board of Obstetrics and Gynecology in both general obstetrics and gynecology and MFM.

4. I am an elected member of the National Academy of Medicine, a Fellow of the American College of Obstetricians and Gynecologists ("ACOG"), and a Fellow of the Society of Maternal-Fetal Medicine ("SMFM").

5. I also serve as the Women's Health Service Line Leader at a major health system in Austin, Texas.

6. I provide the following testimony based on my personal knowledge as well as my training and experience as an OB/GYN and MFM specialist. The statements in this declaration are attributable solely to me; I do not speak on behalf of any institution or organization with which I am affiliated.

7. As an MFM doctor, I specialize in treating patients with high-risk pregnancies. A number of factors can make a pregnancy high risk, including underlying medical conditions such as diabetes and high blood pressure, diagnosed fetal anomalies, multiple gestations, a history of adverse pregnancy outcomes; and pregnancy-related complications such as pre-eclampsia. Approximately ten percent of all pregnancies in the United States are high risk. I also treat patients with low-risk pregnancies.

8. The risks of pregnancy generally increase with gestational age.

9. I see patients in both outpatient and inpatient settings. The medical care I provide is informed by evidence-based guidelines published by ACOG and SMFM. These organizations have recently published special guidelines for patient care during the COVID-19 pandemic that incorporate recommendations from the Centers for Disease Control and Prevention ("CDC").

10. Under normal circumstances, I would typically see a patient for routine prenatal care every four weeks until the middle of the second trimester, and more often after that. High-risk patients generally require more frequent visits. Currently, because of COVID-19, I have reduced

in-person visits for my low risk patients by fifty percent. Every other visit is now conducted via telemedicine. This means that I am still seeing most patients at least twice during the first trimester. I have not changed the frequency of in-person visits for high-risk patients.

11. At each in-person prenatal visit, I collect a urine sample from the patient. Sometimes, I also collect a blood sample.

12. As a result of COVID-19, I have reduced the number of ultrasound examinations that my patients receive. I currently perform an ultrasound when I see a patient for the first time to determine gestational age and whether the patient is carrying multiples. I perform a second ultrasound at 20 weeks. Patients with complications may require additional ultrasounds.

13. Ultrasound examinations can be performed either trans-vaginally or trans-abdominally. A number of factors influence the choice of ultrasound method including the gestational age of the pregnancy, the size and shape of the patient's body, and the quality of the ultrasound machine.

14. My colleagues and I always wear gloves when performing trans-vaginal ultrasound examinations. There is no national recommendation concerning the use of gloves for trans-abdominal ultrasounds. I do not wear them during trans-abdominal ultrasound examinations, but some practitioners do.

15. Phlebotomists and laboratory technicians always wear gloves when collecting or handling blood or urine samples.

16. For routine prenatal visits in an outpatient setting, I typically do not use PPE when meeting with the patient unless the patient is experiencing symptoms of COVID-19 or is at high risk for contracting the virus. My colleagues and I generally try to screen out these patients and refer them for testing, but some require urgent treatment.

17. For example, I saw a pregnant patient last week who had fever and a cough but required immediate care for a pregnancy-related issue. The patient and I both wore surgical masks during our encounter, and I also wore a gown and gloves. Other staff members who were assisting me wore surgical masks, gowns and gloves as well.

18. In the hospital, my colleagues and I are currently using N-95 respirator masks, gowns, and sterile gloves for all Caesarian sections. We are using standard surgical masks and sterile gloves for vaginal deliveries.

19. Pregnant patients come to the hospital for a variety of reasons prior to delivery. In a typical day, our center may see 30 to 40 pregnant patients presenting with various conditions and injuries. Surgical masks, gowns, and gloves are required for treating any pregnant patient who presents at the hospital with symptoms of COVID-19, and some or all of this PPE may be required to care for asymptomatic patients, depending on the type of treatment they need. In addition, anyone performing trans-vaginal ultrasound at the hospital or handling blood or urine samples wears gloves.

20. There is no doubt in my mind that delaying a pregnant patient's abortion by weeks or months will result in a net increase in the consumption of PPE because the imaging and laboratory tests alone needed during early pregnancy require the use of more PPE than is typically used in connection with an abortion. Preventing a patient from having a wanted abortion altogether will result in an even greater net increase in the consumption of PPE because the healthcare providers treating a woman who carries to term will utilize far more PPE over the course of the pregnancy and during delivery than would be needed for an abortion.

Dated: April 2, 2020

George Macones

George A. Macones, M.D., M.S.C.E.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE; *et al.*,	)	
	)	CIVIL ACTION
Plaintiffs,	)	
	)	CASE NO. 1:20-CV-00323-LY
v.	)	
	)	
GREG ABBOTT, in his official capacity as Governor; *et al.*,	)	
	)	
Defendants.	)	

DECLARATION OF AMY HAGSTROM MILLER

AMY HAGSTROM MILLER hereby declares under penalty of perjury that the following statements are true and correct:

1. I am the President and Chief Executive Officer ("CEO") of Whole Woman's Health Alliance ("WWHA"), a plaintiff in this case.

2. WWHA is a nonprofit organization incorporated under Texas law. Its mission is to provide abortion care in underserved communities and shift the stigma around abortion in our culture.

3. WWHA currently operates an abortion clinic in Austin, Texas (the "Austin clinic"), as well as abortion clinics in Indiana and Virginia. The Austin clinic opened in 2017 and is licensed in accordance with Texas law.

4. As President and CEO of WWHA, I oversee all aspects of the organization's work.

5. I have been working in the abortion care field since 1989. Prior to my work at WWHA, I founded a consortium of limited liability companies involved in the provision of abortion care throughout the United States. These companies do business under the name "Whole

Woman's Health." I continue to serve as President and CEO of Whole Woman's Health, which opened its first abortion clinic in 2003.

6. I am thoroughly familiar with all aspects of abortion clinic operations and patient care.

7. I provide the following testimony based on my personal knowledge and review of WWHA's business records.

Provision of Abortion Care at the Austin Clinic

8. The Austin clinic provides surgical abortions up to 17.6 weeks of pregnancy as measured from the first day of a patient's last menstrual period ("lmp"). Under Texas law, licensed abortion facilities are not permitted to provide surgical abortions beyond this gestational age. *See* Tex. Health & Safety Code § 171.004.

9. The Austin clinic provides medication abortions up to 70 days lmp. Under Texas law, medication abortions are prohibited after this gestational age. *See* Tex. Health & Safety Code § 171.063(a)(2).

10. In a typical week, the Austin clinic provides surgical abortions to approximately 30 patients.

11. In a typical week, the Austin clinic provides medication abortions to approximately 30 patients.

12. Texas law requires abortion patients who reside within 100 miles of a licensed abortion clinic to make two separate visits to the clinic to obtain care. *See* Tex. Health & Safety Code § 171.012(a)(4), (b). During the first visit, we must provide the patient with certain state-mandated information and perform an ultrasound examination. *See id.* During the second visit, we provide abortion care. Most of our patients reside within 100 miles of the Austin clinic.

13. Providing abortion care requires minimal use of personal protective equipment ("PPE"). In fact, medical staff members at the Austin clinic do not utilize any PPE when providing medication abortion to patients. Doctors who provide surgical abortions at the Austin clinic typically wear sterile or non-sterile gloves that are discarded after each procedure but do not utilize other forms of PPE. If a patient is receiving sedation, a nurse is also present in the procedure room and will utilize sterile or non-sterile gloves. One or more surgical assistants may also be present for a procedure, but they do not utilize any PPE.

14. Likewise, pre-procedure ultrasound examinations require minimal PPE. Use of PPE is typically not required at all for abdominal ultrasound examinations. For vaginal ultrasound examinations, doctors and ultrasound technicians typically wear non-sterile gloves that are discarded after each scan. When laboratory testing is required, technicians likewise utilize only non-sterile gloves.

15. Following a surgical abortion procedure, the tissue removed from a patient is examined in the pathology laboratory. This task is typically performed by a single staff member who utilizes one washable gown per shift, either one disposable face shield per shift or one set of reusable goggles, one set of disposable shoe covers per shift, one disposable hair cap per shift, and one or more sets of non-sterile gloves.

16. WWHA does not use or have any N95 respirators.

17. Abortion patients seldom require hospitalization. The Austin clinic had only a single hospital transfer during all of last year. Further, we keep detailed complication logs that record, among other things, when a patient receives hospital treatment after being discharged from the clinic. This happens only a handful of times each year.

WWHA's Response to the COVID-19 Outbreak

18. In response to the COVID-19 outbreak, WWHA has adopted policies to protect its patients and staff members from exposure to the virus.

19. For example, staff members screen all patients by telephone before they come to the Austin clinic to determine if they have symptoms of COVID-19. Symptomatic patients are directed to self-quarantine and contact their primary healthcare providers. We will not schedule a patient for a clinic visit unless the patient has been symptom free for fourteen days. We are also limiting the number of people who enter the clinic and ensuring that patients maintain a safe distance from one another in the waiting room and recovery area. In addition, we are screening staff members for symptoms and directing everyone who is symptomatic or who has come in contact with someone who has a confirmed case of the virus to self-quarantine for at least fourteen days.

20. We have provided staff members with training on best practices to prevent the spread of infection, and we are vigilant about enforcing protocols for hand washing and disinfecting surfaces. In other states, we have begun using telehealth platforms for pre-abortion counseling, which reduces unnecessary trips to the clinic for patients and providers, but Texas law requires that certain mandatory disclosures be delivered in person prior to the abortion.

Suspension of Services Following the Governor's Executive Order

21. On March 22, 2020, Texas Governor Greg Abbott issued Executive Order GA-09 ("Executive Order"), relating to hospital capacity during the COVID-19 pandemic. It is in effect until 11:59 p.m. on April 21, 2020, although it may be extended. It directs "all licensed health care professionals and all licensed health care facilities" to "postpone all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or to preserve

the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician." *Id.* at 1. The Executive Order states that this prohibition does not apply to "any procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster." *Id.*

22. Although the order does not define PPE, I understand that term to refer to surgical masks, N95 respirators (a face covering that is designed to block at least 95 percent of very small test particles and which, when used appropriately, is a more effective filtration system than a surgical mask), sterile and non-sterile gloves, disposable protective eyewear, disposable gowns, and disposable shoe covers.

23. I believe that the Austin clinic can continue to provide abortion care in a manner consistent with the Executive Order, and WWHA has adopted policies and procedures to ensure that the care that we provide while the Executive Order remains in effect is fully compliant with its letter and spirit.

24. On Monday, March 23, 2020, WWHA received a copy of an email from the Texas Office of the Attorney General announcing a press release by Attorney General Ken Paxton. That press release was entitled "Health Care Professionals and Facilities, Including Abortion Providers, Must Immediately Stop All Medically Unnecessary Surgeries and Procedures to Preserve Resources to Fight COVID-19 Pandemic."

25. The press release states that the Executive Order applies to "all surgeries and procedures that are not immediately medically necessary," including "most scheduled healthcare procedures that are not immediately medically necessary such as orthopedic surgeries or any type

of abortion that is not medically necessary to preserve the life or health of the mother." It states that a "[f]ailure to comply with an executive order issued by the governor related to the COVID-19 disaster can result in penalties of up to $1,000 or 180 days of jail time" and warns that "[t]hose who violate the governor's order will be met with the full force of the law."

26. WWHA reasonably fears the Attorney General's threat of enforcement, given that the Attorney General and other enforcement officials may understand the Executive Order to prohibit "any type of abortion" that entails the use of PPE even though the Executive Order expressly permits abortions that WWHA's physicians have determined are necessary to "correct a serious medical condition of … a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician," and/or those that "would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 health disaster."

27. Based on this enforcement risk, WWHA has cancelled appointments for more than 20 abortion patients since receiving the Attorney General's press release. At least two of these patients were in the second-trimester of pregnancy and will be past the legal limit for abortion in Texas by the time the Executive Order expires.

28. Patients continue to call the clinic to schedule appointments. We have to turn them away unless we can be sure that no aspect of their care will require the use of PPE. We expect that, between today and April 21, 2020, we will have to turn away dozens of patients.

29. The Austin clinic's capacity is limited by the size of the facility, doctor availability, and the need for most patients to make two trips to the clinic to obtain care. The maximum capacity of the Austin clinic is sixty to seventy patients per week. Even if we were able to resume providing

abortion care on April 22, 2019, which is uncertain, we would not be able to treat all the patients who had been previously been turned away within a week.

Impact on Patients

30. Our patients seek abortion care for a variety of reasons. Many do not have the resources to add an additional child to their family. Some are students who want to complete their education before having children. Some do not want to be tied financially or emotionally to the putative father, or fear abuse if their pregnancy is discovered.

31. Many of the patients who seek care at the Austin clinic are low-income, and many are parents of dependent children. The majority are uninsured.

32. It would be difficult for many of our patients to travel out of state to access abortion care even during normal times. But now, given the travel restrictions and business closures resulting from the COVID-19 crisis, it is nearly impossible. Moreover, in the current circumstances, long-distance travel is both risky and nerve-wracking.

33. Being forced to delay a wanted abortion is also nerve-wracking. Patients who are delayed from accessing abortion must continue to cope with the physical symptoms of pregnancy, which for many include morning sickness. Weight gain will require some to buy new clothes, which can be a financial strain. The longer a patient remains pregnant, the more likely it is that others will discover the pregnancy, including abusive partners or family members. Patients who are delayed from accessing abortion must also cope with the fear of not being able to obtain abortion care in time—and of the life-altering consequences of having to carry an unwanted pregnancy to term.

34. Patients who are delayed past 70 days lmp are no longer eligible for a medication abortion. *See* Tex. Health & Safety Code § 171.063(a)(2). Patients who are delayed past 14-16

weeks lmp are no longer eligible for an aspiration abortion, a type of surgical abortion available early in pregnancy, and must instead have a D&E abortion, which is a lengthier and more complex procedure. Patients who are delayed past 17.6 weeks lmp are no longer eligible for an abortion at the Austin clinic or any abortion clinic in Texas. *See* Tex. Health & Safety Code § 171.004. Patients who are delayed past 22 weeks lmp are no longer able to obtain an abortion in Texas at all, absent a medical emergency. *See* Tex. Health & Safety Code § 171.044.

35. The cost of abortion care (as well as the medical risks of pregnancy and abortion) increase significantly with gestational age.

36. The patients that the Austin clinic is forced to turn away because of the Attorney General's threat of enforcement will therefore be harmed in significant and irreparable ways.

Dated: March 25, 2020

Amy Hagstrom Miller

AMY HAGSTROM MILLER

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, *et al.*, Plaintiffs, v. GREG ABBOTT, in his official capacity as Governor of Texas, *et al.*, Defendants.	No. 1:20-cv-00323-LY

DECLARATION OF TRAM NGUYEN IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Tram Nguyen, declare as follows:

1. I am the Senior Director of Quality Assurance & Abortion Access at Planned Parenthood Gulf Coast ("PPGC"), as well as the Ambulatory Surgical Center Administrator at Plaintiff Planned Parenthood Center for Choice ("PPCfC"), where I have worked since 2006.

2. In my role at PPCfC, I am responsible for the total operation of the ASC, as well as the quality assurance of our healthcare delivery at both PPCfC and PPGC.

3. I submit this declaration in further support of Plaintiffs' motion for a preliminary injunction, which seeks to enjoin Executive Order No. GA-09 as applied to previability abortion care, as well as the Texas Medical Board's emergency amendment to 22 TAC § 187.57 ("Emergency Rule"), which imposes the same requirements.

4. The facts and opinions included here are known to me because of my role in overseeing operations related to abortion care at PPCfC's health centers, including coordinating all of our staff who have been forced to call our patients and tell them that their scheduled

appointments for abortion care have been cancelled, as well as from personal knowledge. If called and sworn as a witness, I could and would testify competently thereto.

5. On March 31, 2020, I personally saw patients in one health center seeking to obtain a medication abortion—who had already received their counseling, waited for 24 hours, and obtained their ultrasounds—have to suddenly be turned away without being able to take the pill that they came for, because the temporary restraining order had been stayed, and our doctors no longer felt comfortable providing care. The same happened for patients who were at the health center to receive their procedural abortions.

6. I do not understand how PPE is preserved by this action. Many of the medication abortion patients who have been turned away will no longer be able to have medication abortions after the Executive Order's current expiration date in April 2020, even assuming it expires then, because their pregnancies will have progressed too far. They will instead require procedural abortions, which require more PPE than medication abortions.

7. As of the end of the day on March 31, 2020, PPCFC's ambulatory surgical center had been forced to cancel appointments for abortion services for 170 patients.

8. I know for certain that at least three of these patients will be beyond the gestational age limit in Texas by the time the Executive Order expires on April 21, 2020, assuming it is not extended. This figure is an underestimate, however, because so many of the 170 patients whose appointments were cancelled had not yet had ultrasounds to date their pregnancies.

9. The staff who have had to make the calls to cancel appointments include reception desk staff and staff educators, who counsel patients about their options and obtain informed consent for procedures, as well as call center employees who generally assist with scheduling.

10. My understanding is that patients have been uniformly devastated to learn that they cannot obtain their abortions in the state of Texas.

11. One patient was in the clinic, getting an ultrasound, when she heard that she would not be permitted to return for her abortion because enforcement of the Executive Order as to abortion was no longer enjoined. That patient has obtained a diagnosis of a lethal fetal anomaly—anencephaly. I know that she does not independently have the means to travel out of state to obtain an abortion now that she can no longer have one in Texas. If she cannot obtain abortion care at all, she will be forced to carry a pregnancy for many months until she either miscarries or she gives birth to a child that is either stillborn or likely to survive only a few hours before dying. Additionally, as the pregnancy progresses, risks for pregnancy-associated complications increase.

12. At least one of our patients already had a child at home, but said that she could not continue on with being forced to have a baby she does not want, implying that she wanted to kill herself and stating that she might try to induce her own abortion. Staff reminded her that she has a child that needs her, encouraged her to see a physician, and gave her resources to call for further assistance.

13. Another patient had been taking medication which is harmful to a pregnancy. When she was told she could not obtain an abortion in Texas, she became hysterical at the thought that she might have to go off her medication. She was so upset she had to pull over to the side of the road, because she could no longer drive safely.

14. Another patient who is not English proficient was so overcome with sobbing that the interpreter could not understand her well enough to interpret anything she was saying.

15. Another patient was stunned that such decisions could be made with such short notice to people, saying, “I was just there an hour ago and had my ultrasound.”

16. Some patients asked about out of state referrals, even though reaching nearby out of state health centers require traveling long distances. Others refused referrals that were offered, because they simply cannot travel out of state at all, meaning they have been entirely denied access to abortion care.

17. Many patients who could travel out of state, however, did so. I have heard from a Planned Parenthood affiliate with health centers in Colorado, New Mexico and Southern Nevada that they saw 30 patients from Texas in the week after the Attorney General's statements applying the Executive Order to abortion, compared with only 16 the prior week. Indeed, I heard that affiliate's health centers saw only 35 patients from Texas in the entire month of February.

18. I know of one patient who is a minor and who obtained a judicial bypass order to get an abortion, and she cannot obtain an abortion in Texas now. I obtained a copy of the judicial bypass order from the minor's attorney, a true and correct copy of which is attached hereto as Exhibit A. That court found, among other things:

a. "Clear and convincing evidence" that the young woman is "mature and sufficiently well-informed to make the decision to have an abortion" and, moreover, that "[n]otifying and attempting to obtain the consent of either the applicant's parents, managing conservator, or guardian would not be in her best interest";

b. That, though the Executive Order was already in place, the patient's ability to obtain an abortion "immediately is medically necessary because compelling her to wait to do so increases the risk to the applicant's health" and that "compelling applicant to wait until after April 21, 2020, restricts her ability to elect to have the abortion that is the safest procedure for her and increases the risk that she will suffer complications if she elects to have an abortion" and

c. That neither medication abortion nor procedural abortion is prohibited by the Executive Order because neither method of abortion "depletes hospital capacity or personal protective equipment needed to cope with the COVID-19 disaster.

Exhibit A.

19. That minor patient's *guardian ad litem* told me how utterly devastated her client was when she learned that she could no longer obtain an abortion legally in Texas. Given that the client had to obtain a judicial bypass in order to obtain an abortion, it is likely that the patient lacks the resources, both financially and socially, to go out of state to obtain her abortion.

20. After the District Court for the Western District of Texas issued the Temporary Restraining Order on March 30, 2020, and before the Fifth Circuit Court of Appeals stayed that order, I began calling patients back to reschedule their appointments.

21. I cannot sufficiently describe how relieved patients were that they would be able to get their care. Those patients who were making arrangements to leave the state for care were incredibly relieved that they did not have to go out of state.

22. I can only imagine how devastated they will be to learn that their care is, once again, cancelled and that they cannot obtain an abortion. This is particularly true for patients whose pregnancies will have progressed too far to obtain an abortion in Texas once the Executive Order has expired and who will be forced to carry their pregnancies to term. This is also true for patients whose pregnancies will have progressed to the point that they will require a more expensive and involved two-day abortion procedure (which also uses more personal protective equipment). Many of our patients are already on the brink financially as it is, with one patient telling me recently that, due to COVID-19, the money she had saved to travel to obtain her abortion had to be spent on groceries for that week.

23. Even if the Executive Order is not extended, I worry that all the patients who have been denied abortion care will need an appointment at the same time, and that this will create a serious backlog, meaning that patients will need to wait even longer to get the abortion care they

need. Based on the number of patients we have had to turn away so far[1], I would expect a backlog of at least six weeks, assuming the Executive Order is not extended. That means many patients will have been delayed over two months in obtaining an abortion, assuming their pregnancies had not progressed so far that they could no longer obtain an abortion in Texas.

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

Tram Nguyen

Executed April 2, 2020

[1] The true number of patients turned away includes not only patients whose appointments for abortion care were canceled, it also includes patients who had appointments cancelled for their ultrasound, which Texas law requires be done at least 24 hours prior to the abortion appointment, meaning these patients never had an appointment made for their abortion care.

EXHIBIT A

CAUSE NO. 2020-17737

IN RE JANE DOE	§	**IN THE 232nd DISTRICT COURT**
	§	
	§	
	§	**HARRIS COUNTY, TEXAS**

JUDGMENT AND FINDINGS OF FACT AND CONCLUSIONS OF LAW

This matter was heard on March 24, 2020. Based on the testimony and the evidence presented, the Court FINDS:

1. The applicant is pregnant.

2. The applicant is unmarried and under 18 years of age.

3. The applicant has not had her disabilities as a minor removed under Chapter 31 of the Texas Family Code.

4. The applicant wishes to have an abortion without her doctor notifying and obtaining the consent of either of her parents, her managing conservator, or her guardian.

5. Clear-and-convincing evidence supports the following finding(s):

   ✓ The applicant is mature and sufficiently well-informed to make the decision to have an abortion performed without notification to, or the consent of, either of her parents, her managing conservator, or guardian.

   ✓ Notifying and attempting to obtain the consent of either of the applicant's parents, managing conservator, or guardian would not be in her best interest.

6. The evidence also supports the following findings and conclusions:

   _____ If applicant elects to have an abortion, her ability to exercise her right to do so immediately is medically necessary because compelling her to wait to do so increases the risk to applicant's health. Specifically, early medical abortions (non-surgical abortions) are limited to the first 9 weeks of pregnancy, and those medical abortions have the least serious complications, occurring in less than .5% of cases. Aspiration abortions (surgical abortions) have the next least serious complications, with 97% of women reporting no complications; 2.5% having minor complications that can be handled at a medical office or abortion facility; and less than .5% having more serious complications. Complication rates are higher for surgical abortions provided after 13 weeks than in first-trimester procedures.

✓ Applicant is approximately 10 weeks pregnant. The Governor's Executive Order No. GA-09, signed on March 22, 2020, remains in effect until 11:59 p.m. on April 21, 2020, unless it is modified, amended, rescinded, or superseded by the Governor or his successor. If applicant elects to have an abortion, her ability to exercise her right to do so immediately is medically necessary because compelling her to wait to do so increases the risk to applicant's health. Specifically, compelling applicant to wait until after April 21, 2020, restricts her ability to elect to have the abortion that is the safest procedure for her and increases the risk that she will suffer complications if she elects to have an abortion.

____ Applicant is approximately ___ weeks pregnant. The Governor's Executive Order No. GA-09, signed on March 22, 2020, remains in effect until 11:59 p.m. on April 21, 2020, unless it is modified, amended, rescinded, or superseded by the Governor or his successor. If the Governor's order is extended past April 21, 2020, applicant's right to elect to have an abortion will be effectively eliminated because such an abortion would occur after the cutoff for applicant to obtain a legal abortion. Eliminating applicant's ability to elect to have an abortion increases the risk to applicant's health as she would be statistically more likely to die during or after giving birth than to die from complications from an abortion.

✓ The Governor's Executive Order No. GA-09 does not apply to medical abortions because those, if performed in accordance with the commonly accepted standards of clinical practice, would not deplete the hospital capacity or personal protective equipment needed to cope with the COVID-19 disaster.

✓ The Governor's Executive Order No. GA-09 does not apply to surgical abortions that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster.

Therefore, it is ORDERED:

✓ The application is GRANTED and the applicant is authorized to consent to the performance of an abortion without notifying and obtaining the consent of either of her parents or a managing conservator or guardian.

____ The application is DENIED. The applicant is advised of her right to appeal under Rule 3 of the Rules for a Judicial Bypass of Parental Notice and Consent Under Chapter 33 of the family Code and will be furnished a Notice of Appeal form, Form 3A.

All costs shall be paid by the State of Texas pursuant to Family Code Chapter 33.

Daryl L. Moore 3/24/20

Judge Presiding

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, *et al.*, Plaintiffs, v. GREG ABBOTT, in his official capacity as Governor of Texas, *et al.*, Defendants.	No. 1:20-cv-00323-LY

DECLARATION OF FRANCES NORTHCUTT IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Frances "Poppy" Northcutt, declare as follows:

1. I am an attorney licensed to practice law in the state of Texas. I have been practicing for nearly forty years.

2. I frequently represent minors as their attorney in obtaining judicial bypasses to obtain abortions in Texas without parental notification and consent. I also am occasionally appointed as a *guardian ad litem* for minors seeking judicial bypasses.

3. I have been assisting minors in obtaining judicial bypasses since the Texas bypass statute was first adopted in 1999. I am very familiar with the complex and often devastating life circumstances that lead these young women to not only need an abortion, but also to need a judicial bypass. Some of the young women I have represented have been orphaned and have no one who is legally authorized to sign for them to have an abortion. Others have no parent available to sign for them because the parent is in another country, is mentally or physically incapacitated, has abandoned the

family, or is incarcerated. Some are refugees from foreign lands separated from their parents by war. Some are sexual assault victims. Many come from homes where they are physically or emotionally abused.

4. I have watched with dismay over the last week as the young women whose interests I represent, who are already in a crisis situation, have been informed that, although they have gone through the process of convincing a Texas judge by clear and convincing evidence that they satisfy the requirements for a judicial bypass, they *still* may not legally have an abortion in Texas. In my experience, these young women are in no position to travel out of state to obtain medical care, as they lack the financial, social, and familial resources to do so.

5. One young woman for whom I acted as *guardian ad litem* obtained a judicial bypass because she already has a child and, if her mother discovers that she is pregnant again, she and her existing child will be kicked out of their home and become homeless. Her abortion appointment has been cancelled twice now due to Executive Order No. GA-09. She was devastated when she received the news. At the time that she received her judicial bypass, her pregnancy was in the first trimester. Now with the repeated cancellations, her pregnancy has moved into the second trimester, which makes the procedure more costly and more complicated, and she meanwhile risks becoming a homeless pregnant teen with a young child. I have no idea how she could possibly obtain an abortion out of state.

6. I recently represented another minor who obtained a judicial bypass only to have her appointment cancelled. She is seeking to escape an abusive relationship while also caring for an elderly relative who has cancer. She and her elderly

relative were alarmed when they learned of the health center's suspended services and concerned about the difficulty of traveling out of state to obtain an abortion.

7. The harm these young women will suffer from not being able to timely obtain abortion care is great and irreparable. They cannot wait three weeks for the Executive Order to expire (even if the Executive Order is not extended, as it seems likely to be). They are in no position economically to travel great distances to obtain an abortion. Each of them has expressed to me their emotional distress at being denied access to a safe and legal abortion. Each has found it confounding to be told by local officials that in response to the COVID-19 virus they should stay at home and not travel while being forced by state officials to either carry a pregnancy against their will, which is riskier to them than an abortion, or to endanger themselves and others by traveling out of state to secure a safe and legal abortion.

Executed April 1, 2020

Frances Northcutt

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, *et al.*,

Plaintiffs,

v.

GREG ABBOTT, in his official capacity as Governor of Texas, *et al.*,

Defendants.

No. 1:20-cv-00323-LY

DECLARATION OF ANN SCHUTT-AINE, M.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

I, Ann Schutt-Aine, M.D., declare as follows:

1. I am a board-certified obstetrician and gynecologist licensed to practice in the state of Texas, and I have been practicing in Houston, Texas, since 2008. I have served as the Chief Medical Officer of Planned Parenthood Center for Choice ("PPCFC") since 2017.

2. PPCFC is a Texas not-for-profit corporation that is headquartered in Houston. It operates a licensed ambulatory surgical center in Houston and a licensed abortion facility in Stafford. PPCFC and its predecessor organizations have provided abortion in Houston and southeast Texas since 1973.

3. In my current role at PPCFC, I supervise physicians and clinicians and have oversight responsibility for PPCFC's medical services. This includes responsibility for the quality assurance of those medical services, as well for the promulgation of and adherence to the medical protocols pursuant to which the services are provided. I also provide abortion care.

4. I submit this declaration in support of Plaintiffs' motion for a temporary restraining order followed by a preliminary injunction, which seeks to enjoin Executive Order No. GA-09 as interpreted by the Texas Attorney General to ban all previability abortion in the state except where immediately necessary to protect the life or health of a pregnant person, as well as the Texas Medical Board's emergency amendment to 22 TAC § 187.57 ("Emergency Rule"), which imposes the same requirements as the Executive Order. I am familiar with the Executive Order, the Emergency Rule, and a press release by the Texas Attorney General interpreting the Executive Order.

5. The facts and opinions included here are based on my education, training, practical experience, information, and personal knowledge I have obtained as an OBGYN and an abortion provider; my attendance at professional conferences; review of relevant medical literature; and conversations with other medical professionals. If called and sworn as a witness, I could and would testify competently thereto.

6. My curriculum vitae, which sets forth my experience and credentials more fully, is attached as Exhibit A.

The Executive Order and Threatened Enforcement

7. On March 22, 2020, Texas Governor Greg Abbott issued the Executive Order, relating to hospital capacity during the COVID-19 pandemic. That order is in effect until 11:59 p.m. on April 21, 2020, although it may be extended. It directs "all licensed health care professionals and all licensed health care facilities" to "postpone all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician."

Id. at 1. The Executive Order states that this prohibition does not apply to "any procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment ["PPE"] needed to cope with the COVID-19 disaster." *Id.*

8. Although the order does not define PPE, I understand that term to refer to surgical masks, N95 respirators (a face covering that is designed to block at least 95 percent of very small test particles and which, when used appropriately, is a more effective filtration system than a surgical mask), sterile and non-sterile gloves, protective eyewear, gowns, and shoe covers.

9. PPCFC has adopted a policy to implement the Executive Order, a true and correct copy of which is attached as Exhibit B. That policy permitted PPCFC to continue offering procedural and medication abortion, consistent with the Executive Order's purpose and plain language and the views of trusted national medical organizations.

10. On Monday, March 23, 2020, PPCFC received a copy of an email from the Texas Office of the Attorney General announcing a press release by Attorney General Ken Paxton. A true and correct copy of that release, entitled "Health Care Professionals and Facilities, Including Abortion Providers, Must Immediately Stop All Medically Unnecessary Surgeries and Procedures to Preserve Resources to Fight COVID-19 Pandemic," is attached as Exhibit C.

11. The press release states that the Executive Order applies to "all surgeries and procedures that are not immediately medically necessary," including "most scheduled healthcare procedures that are not immediately medically necessary such as orthopedic surgeries or any type of abortion that is not medically necessary to preserve the life or health of the mother." It states that a "[f]ailure to comply with an executive order issued by the governor related to the COVID-

19 disaster can result in penalties of up to $1,000 or 180 days of jail time" and warns that "[t]hose who violate the governor's order will be met with the full force of the law."

PPCFC's Provision of Abortion Care

12. Legal abortion is one of the safest medical procedures in the United States.[1] There are two main methods of abortion: medication abortion and procedural abortion. Both methods are effective in terminating a pregnancy.[2] Complications from both medication and procedural abortion are rare, and when they occur they can usually be managed in an outpatient clinic setting, either at the time of the abortion or in a follow-up visit. Major complications—defined as complications requiring hospital admission, surgery, or blood transfusion—occur in less than one-quarter of one percent (0.23%) of all abortion cases: in 0.31% of medication abortion cases, in 0.16% of first-trimester procedural abortion cases, and in 0.41% of procedural cases in the second trimester or later.[3] Abortion-related emergency room visits constitute just 0.01% of all emergency room visits in the United States.[4]

13. Medication abortion involves a combination of two pills: mifepristone and misoprostol.[5] The patient takes the first medication in the health center and then, typically twenty-four to forty-eight hours later, takes the second medication at a location of their choosing, most

[1] Nat'l Acads. of Scis. Eng'g & Med., The Safety & Quality of Abortion Care in the United States 77–78, 162–63 (2018).

[2] Luu Doan Ireland et al., *Medical Compared With Surgical Abortion for Effective Pregnancy Termination in the First Trimester*, 126 Obstetrics & Gynecol. 22 (2015).

[3] Ushma Upadhyay, et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecol. 175 (2015).

[4] Ushma Upadhyay, et al., *Abortion-related Emergency Room Visits in the United States: An Analysis of a National Emergency Room Sample*, 16(1) BMC Med. 1, 1 (2018).

[5] Nat'l Acads., *supra* note 1, at 51.

often at their home, after which they expel the contents of the pregnancy in a manner similar to a miscarriage. Medication abortion is not a "procedure."

14. Current medical evidence demonstrates that medication abortion is safe and effective through eleven weeks of pregnancy as measured from the first day of a pregnant patient's last menstrual period ("LMP"). However, Texas law, Tex. Health & Safety Code § 171.063, restricts the first drug used in medication abortion to use as described in the federally approved label, which is for pregnancies less than ten weeks. *See* FDA, *Mifeprex (mifepristone) Information* (last updated Feb. 5, 2018), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information. Accordingly, although PPCFC would provide medication abortion up to eleven weeks LMP if it could legally do so, it currently cannot provide this method of abortion in Texas beyond ten weeks LMP (through seventy days).

15. Texas law also requires that medication abortion be preceded by an ultrasound, Tex. Health & Safety Code § 171.012(a)(4), and followed by an in-person follow-up appointment within fourteen days, Tex. Health & Safety Code § 171.063(a)(2), (e), even though neither step is medically necessary in every case.

16. While sometimes referred to as "surgical abortion," procedural abortion is not what is commonly understood to be "surgery"; it involves no incision, no need for general anesthesia, and no requirement of a sterile field. Up to approximately fifteen weeks LMP, clinicians use the aspiration abortion technique, which involves dilating the natural opening of the cervix using medications and/or small, expandable rods, inserting a narrow, flexible tube into the uterus, and emptying the uterus through suction. This procedure typically takes five to ten minutes. To perform abortions after that gestational point in pregnancy, clinicians must dilate the cervix further and use instruments to empty the uterus, which is called the dilation and evacuation ("D&E") technique.

Later in the second trimester, the clinician may begin cervical dilation the day before the procedure itself. In the absence of a lethal fetal anomaly, PPCFC performs procedural abortion up to twenty-one weeks, six days LMP.

17. For some patients with pregnancies less than ten weeks LMP, medication abortion is not available because it is contraindicated or there are other factors that necessitate a procedural abortion, such as where the patient has an allergy to the medications or other medical conditions that make procedural abortion relatively more safe.[6]

18. In 2019, PPCFC performed 6,152 abortions. Of those, 1,083 occurred beyond ten weeks LMP, and were therefore necessarily performed as procedural abortion. Of those 5,069 occurring before ten weeks LMP, 2,877 were done by procedural abortion and the remainder by medication abortion.

19. In January and February 2020, PPCFC performed 1,074 abortions, 216 of which occurred beyond ten weeks LMP and were therefore necessarily performed as procedural abortions. Of those 858 abortions occurring before ten weeks LMP, 429 were done by procedural abortion and the remainder by medication abortion.

20. Individuals seek abortion for a multitude of complicated and personal reasons. By way of example, some patients have abortions because they conclude it is not the right time to become a parent or have additional children,[7] they desire to pursue their education or career, or they lack the necessary financial resources or a sufficient level of partner or familial support or

[6] Nat'l Acads., *supra* note 1, at 51–52.

[7] Indeed, a majority of women having abortions in the United States already have at least one child. Guttmacher Inst., Induced Abortions in the United States 1 (2018), https://www.guttmacher.org/sites/default/files/factsheet/fb_induced_abortion.pdf; *see also* Jenna Jerman, Rachel K. Jones & Tsuyoshi Onda, Guttmacher Inst., Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008, at 6, 7 (2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

stability.[8] Other patients seek abortions because continuing with the pregnancy could pose a greater risk to their health.[9] Indeed, while much is unknown about COVID-19, including whether it can complicate pregnancy, some pregnant people may be exposed to additional health risks from the disease. The American College of Obstetricians and Gynecologists ("ACOG") has warned that "pregnant women are known to be at greater risk of severe morbidity and mortality from other respiratory infections such as influenza and SARS-CoV. As such, pregnant women should be considered an at-risk population for COVID-19."[10]

21. The window during which a patient can obtain an abortion in Texas is limited. Pregnancy is generally forty weeks in duration, but Texas prohibits abortion after twenty-two weeks LMP. *See* Tex. Health & Safety Code § 171.044.[11]

22. Although abortion is a very safe medical procedure, the health risks associated with it increase with gestational age.[12] As ACOG and other well-respected medical professional organizations have observed, abortion "is an essential component of comprehensive health care"

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[8] That strain is all the more apparent if one considers that the vast majority—approximately 75%—of abortion patients nationwide are poor or have low incomes. Guttmacher Inst., Induced Abortions in the United States 1, *supra* note 7.

[9] M. Antonia Biggs et al., *Understanding Why Women Seek Abortions in the US*, 13 BMC Women's Health 7 (2013).

[10] Am. Coll. of Obstetricians & Gynecologists, *Practice Advisory - Novel Coronavirus 2019 (COVID-19)* (last updated Mar. 13, 2020), https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/03/ novel-coronavirus-2019; see also Ctrs. for Disease Control & Prevention, *Information for Healthcare Providers: COVID-19 and Pregnant Women* (last updated Mar. 16, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/pregnant-women-faq.html.

[11] This provision prohibits an abortion when "the probable post-fertilization age of the unborn child is 20 or more weeks." *Id.* "Post-fertilization age" means "the age . . . as calculated from the fusion of a human spermatozoon with a human ovum," *id.* § 171.042, which is two weeks before a patient's last menstrual period. Thus, twenty weeks post-fertilization age is twenty-two weeks LMP.

[12] Nat'l Acads., *supra* note 1, at 77–78, 162–63.

and "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks [to patients] or potentially make it completely inaccessible."[13]

23. Patients generally seek abortion as soon as they are able, but many face logistical obstacles that can delay access to abortion care. Patients will need to schedule an appointment, gather the resources to pay for the abortion and related costs,[14] and arrange transportation to a clinic, time off of work (often unpaid, due to a lack of paid time off or sick leave), and possibly childcare during appointments.[15] Texas law requires most patients to make these arrangements multiple times even though they could just as safely obtain care in one visit. Tex. Health & Safety Code § 171.012 (mandating that patients receive an ultrasound at least twenty-four hours before an abortion procedure).[16] Delay results in higher financial and emotional costs to the patient. Minor patients, unless emancipated, must also obtain written consent from a parent or a judicial order before they can receive care. Tex. Family Code § 33.003.

24. The COVID-19 pandemic has only exacerbated these burdens on patients seeking abortion care. It has limited public transit availability, caused layoffs and other work disruptions,

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[13] ACOG et al., *Joint Statement on Abortion Access During the COVID-19 Outbreak* (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak.

[14] Texas prohibits public insurance, including Medicaid, and insurance purchased on the state health exchange from covering abortion services except in the very limited circumstances where a patient's physical health or life is at risk, or where the pregnancy is a result of rape or incest that has been reported to law enforcement. Tex. Insurance Code § 1218.001; Tex. Human Resources Code § 32.024.

[15] Jerman et al., *supra* note 7; Sarah E. Baum et al., *Women's Experience Obtaining Abortion Care in Texas After Implementation of Restrictive Abortion Laws: A Qualitative Study*, 11 PLoS One 1, 7–8, 11 (2016); Lawrence B. Finer, Lori F. Frohwirth, Lindsay A. Dauphinee, Susheela Singh, & Ann M. Moore, T*iming of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 Contraception 334, 335 (2006).

[16] A patient who lives more than 100 miles from the nearest abortion provider can rely on a waiver of the twenty-four requirement, but will still be subjected to a two-hour requirement. *See id.*

shuttered schools and childcare facilities, and otherwise limited patients' options for transportation and childcare support during a time of recommended social-distancing.[17] Indeed, jobless claims are soaring due to the virus.[18]

25. Neither medication nor procedural abortion requires extensive PPE or otherwise would deplete PPE. In fact, for medication abortion, providing patients with the medication does not require the use of *any* PPE. And while clinicians performing procedural abortion at PPCFC use some PPE, such as gloves for each procedure, a mask, and protective eyewear, only a small number of workers are physically present for these procedures or their preparation/recovery and therefore in need of PPE.[19] For an ultrasound or laboratory exam, including one that accompanies medication or procedural abortion, we use only non-sterile gloves.

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[17] Tex. Exec. Order No. GA-08 (Mar. 19, 2020) (closing Texas schools and discouraging Texans from participating in non-essential activities); Jacqulyn Powell, *Will Child Care Centers Shut Down During COVID-19 Outbreak?*, KXAN, Mar. 23, 2020, https://www.kxan.com/news/education/will-child-care-centers-shut-down-during-covid-19-outbreak/ ("Statewide, the Department of Health and Human Services says 2,400 child care operations have reported closures due to COVID-19."); Metro. Transit Authority of Harris Cty., *METRO Response to Coronavirus (COVID-19)*, https://www.ridemetro.org/Pages/Coronavirus.aspx (last visited Mar. 24, 2020) (public transit authority in Harris County noting a "sharp ridership decline" and announcing reduced frequency of bus services and reducing customer seating); *see also* White House, *The President's Coronavirus Guidelines for America* (Mar. 16, 2020), https://www.whitehouse.gov/wp-content/uploads/2020/03/03.16.20_coronavirus-guidance_8.5x11_315PM.pdf; Rebecca Shabad, *Fauci Predicts Americans Will Likely Need to Stay Home for at Least Several More Weeks*, NBC News, Mar. 20, 2020, https://www.nbcnews.com/politics/donald-trump/fauci-predicts-americans-will-likely-need-stay-home-least-several-n1164701.

[18] *See* Matt Largey, *COVID-19 Is Costing People Their Jobs. Here's How to Apply for Unemployment in Texas*, KUT 90.5, Mar. 19, 2020, https://www.kut.org/post/covid-19-costing-people-their-jobs-heres-how-apply-unemployment-texas (Texas unemployment claims between March 15 and March 18 were eleven times higher than for the same period in 2019); Tex. Workforce Comm'n, *TWC Extends Call Center Hours* (Mar. 23, 2020), https://twc.texas.gov/news/twc-extends-call-center-hours (Texas Workforce Commission reporting that it has received "an unprecedented call volume as a result of COVID-19").

[19] Per CDC guidance, PPCFC provides patients for whom there is a concern for COVID-19 or other upper respiratory disease with a mask. Ctrs. for Disease Control & Prevention,

26. By comparison, even if a provider of prenatal care reduces the scheduling of such care during the COVID-19 outbreak, it will still involve use of masks, sterile gloves, and potentially other PPE during multiple visits.[20] A patient continuing a pregnancy will thus require significantly more PPE than a patient presenting for abortion. Furthermore, every time a pregnant person presents to the hospital for evaluation prior to labor, which could happen multiple times, this will require the use of masks and sterile gloves. An actual birth could involve anywhere from seven to ten gowns, masks, and sterile gloves.

27. PPCFC does not use or have any N95 respirators, which I understand are the PPE in shortest supply during the COVID-19 pandemic.

28. PPCFC does not provide inpatient care, nor is it set up to do so.

PPCFC's Efforts to Prevent COVID-19 Spread and Conserve Needed Resources

29. PPCFC is committed to doing its part to reduce the spread of COVID-19 and to otherwise help ensure that our public health system has sufficient resources to meet the challenge of responding to a potential surge of illness.

30. Since the COVID-19 outbreak, PPCFC has taken steps to preserve much-needed medical resources and help prevent the spread of COVID-19 in the communities where we offer services. Even before the Governor's order, for example, we had reduced our patient volume to ensure that we comply with current social-distancing recommendations. In addition, although in normal times we welcome support companions accompanying abortion patients, we have decided

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Frequently Asked Questions about Personal Protective Equipment (Mar. 14, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirator-use-faq.html.

[20] ACOG, *Examples of Alternate or Reduced Prenatal Care Schedules* (Mar. 24, 2020), https://www.acog.org/en/Clinical%20Information/Physician%20FAQs/-/media/287cefdb936e4cda99a683d3cd56dca1.ashx.

not to allow such companions (except parents accompanying minors) to enter our health centers in order to reduce the number of overall people exposed to one another.

31. We have also made dramatic changes to the flow of our patient care. Before patients may enter a health center, we screen them for COVID-19 symptoms, including by checking for fever. Only those individuals who are thoroughly screened can proceed to the front desk to check in and provide their phone number. Patients are then asked to wait in their cars, where a nurse will call them to do as much intake as possible by phone. Patients are only permitted to reenter the health center when a room has opened for them and a clinician is available to see them.

Harms Caused by the Executive Order and the Attorney General's Interpretation of It

32. PPCFC reasonably fears the Attorney General's threat of enforcement, given that the Attorney General may understand the Executive Order to prohibit procedural abortions that PPCFC's physicians have determined are necessary to "correct a serious medical condition of … a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician," as permitted by the Executive Order. It also reasonably fears that the Attorney General will understand the order to prohibit medication abortions, despite the fact that these are not "procedures" and therefore do not fall within the terms of the Executive Order at all.

33. Based on this enforcement risk, PPCFC has already cancelled services for more than fifty abortion patients through Wednesday of this week.

34. PPCFC will cancel non-emergency future procedural abortion appointments unless and until the Executive Order and Emergency Rule expire or are rescinded, or unless the Court grants relief. Additionally, because of the AG's interpretation of the Executive Order, we have

cancelled all non-emergency medication abortions until we obtain clarity on the scope of the Executive Order or the Court grants relief.

35. Even if each one of these patients were able to access abortion after the order's current expiration date (i.e., even if the order is not extended), many of the medication abortion patients would require procedural abortions instead (and correspondingly greater amounts of PPE), and some procedural abortion patients would require a comparatively more complicated procedural abortion method using the D&E technique. That technique requires more time in the clinic and a larger number of staff than aspiration abortion, another method of procedural abortion. Moreover, because these patients would continue to be pregnant for a longer period of time, they would also be at increased risk of negative health outcomes if they are diagnosed with COVID-19.[21] Other patients could be foreclosed from receiving an abortion altogether because the delay of the order would extend their pregnancies beyond the legal gestational limit for abortion in Texas.

36. The Executive Order could well exacerbate the COVID-19 crisis, by delaying abortion care for patients with health problems until they need intensive emergency care or by forcing patients to travel to other states, potentially using public transportation, even though public health experts have advised the public to minimize activities outside the home. If the Executive Order, as interpreted by the Attorney General, is enforced, it will deprive PPCFC's patients of the freedom to make a very personal decision, in consultation with their families and doctors, regarding whether to continue or end their pregnancies. It will harm patients' physical, emotional, and financial wellbeing and the wellbeing of their families.

[21] Ctrs. for Disease Control & Prevention, *Information for Healthcare Providers: COVID-19 and Pregnant Women*, *supra* note 10.

37. Without access to PPCFC's abortion services and those of other Texas abortion providers, some patients will be forced to travel hundreds of miles across state lines to try to access abortion care. Given the logistical hurdles of traveling out-of-state, particularly during the COVID-19 pandemic, these patients are likely to obtain abortions later than they would have had they accessed care from PPCFC, which necessarily entails greater risks than an earlier procedure.[22] Efforts to travel are also likely to expose both patients and other people to additional risk of contagion, at a time when other states and Texas's most populous counties have given urgent directives to their citizens to stay home as much as possible to avoid inadvertently spreading the COVID-19 virus.

38. For other patients, travel to another state will simply not be possible to the extent travel remains legally possible during the pandemic. As a result, these patients will be forced to carry unwanted pregnancies to term, resulting in a deprivation of their fundamental right to determine when and whether to have a child or to add to their existing families, as well as greater health and other risks to them and their children.

39. Even if some patients affected by the Executive Order *are* able to obtain an abortion after the order is lifted, they will still suffer increased risks to their health by the delay in access to abortion care.[23] Many will also face increased costs related to abortion, as their abortion access is

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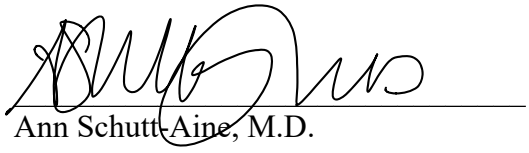
[22] As of this filing, eighteen Texas counties have issued stay-at-home orders. *See* Wes Wilson, *Here's Which Texas Cities and Counties Have Issued Stay-at-Home Orders*, KXAN (last updated Mar. 24, 2020), https://www.kxan.com/news/coronavirus/heres-which-texas-cities-and-counties-have-issued-stay-at-home-orders/; Alex Samuels, *Texas' Largest Counties Are Issuing Stay-at-Home Orders*, Tex. Tribune (Mar. 23, 2020), https://www.texastribune.org/2020/03/23/austin-travis-county-issue-stay-home-order-tuesday/. In some counties, non-compliance with these orders is punishable by fines or jail time. *See, e.g., Texas County's Curfew Amid Coronavirus Spread is Punishable by Fines Up to $1,000, Jail Time*, WHNT News 19 (Mar. 21, 2020), https://whnt.com/news/texas-countys-curfew-amid-coronavirus-spread-is-punishable-by-fines-up-to-1000-jail-time/.

[23] Nat'l Acads., *supra* note 1, at 77–78, 162–63.

pushed to later gestational points when abortion is more expensive and may require a two-day procedure, instead of one. These costs, in turn, will likely lead to additional delay and present an even greater hardship to vulnerable populations during the economic fallout of the COVID-19 pandemic.

40. Although the Order indicates that it will expire after a 30-day period, the likelihood that it will be extended is high. Certainly it is clear that the pandemic is likely to continue well beyond this period.[24]

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



Ann Schutt-Aine, M.D.

Executed March 25, 2020

[24] *See, e.g.*, Ctrs. for Disease Control & Prevention, *Healthcare Supply of Personal Protective Equipment*, (last updated Mar. 14, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/healthcare-supply-ppe.html.

EXHIBIT A

Ann I. Schutt-Ainé, MD, FACOG

Education and Training

Undergraduate:	
September 1992 – May 1996	Yale University New Haven, CT BS, Biology, 1996 *cum laude*, distinction in Biology
Graduate:	
September 1996 – June 2000	Harvard Medical School Boston, MA MD, 2000
Postgraduate:	
June 2000 – June 2004	Magee-Womens Hospital of the University of Pittsburgh Medical Center Pittsburgh, PA

Obstetrics, Gynecology and Reproductive Sciences

Professional Experience

August 2017 – Present	Chief Medical Officer Planned Parenthood Gulf Coast Houston, TX
April 2017 – August 2017	Medical Director Planned Parenthood Gulf Coast Houston, TX
September 2008 – Present	Assistant Professor, Obstetrics and Gynecology Baylor College of Medicine Houston, TX
September 2011 – March 2017	Associate Medical Director Planned Parenthood Gulf Coast and PPCfC Houston, TX
August 2008 – Present	Contract Physician Planned Parenthood Center for Choice (PPCfC) Houston, TX
August 2007 – July 2008	Associate Medical Director, Ob/Gyn

	Planned Parenthood Golden Gate San Francisco Bay Area
July 2004 – July 2007	Obstetrician/Gynecologist Primary Care Health Services, Inc. Pittsburgh, PA
March 2004 – June 2007 Planned Parenthood of Western Pennsylvania	Contract Physician Pittsburgh, PA

ADDITIONAL TRAINING/EXPERIENCE

October 2018 – March 2019	US Physician Leadership Academy *A six-month program produced by Deloitte and the Wharton School, "targeted to practicing physicians who have taken on increasing levels of leadership and administrative responsibility in their careers and aspire to be enterprise-wide leaders."*
February 2015	Excellence in Family Planning Research Course *An intensive one week course in epidemiology, research design, and evidence-based medicine.*
September 2009 – April 2010	Fellow – Leadership Training Academy Physicians for Reproductive Choice and Health *An eight-month, intensive program aimed to develop and internalize the skills and attributes needed to be a powerful, effective advocate for comprehensive sexual and reproductive health care.*

APPOINTMENTS AND POSITIONS

ACADEMIC

September 2008 – present Director – Ryan Residency Training Program in Family Planning (2010-2018)	Assistant Professor, Obstetrics and Gynecology
July 2004 – July 2007	Clinical Assistant Professor of Obstetrics, Gynecology and Reproductive Sciences University of Pittsburgh School of Medicine

NON-ACADEMIC

April 2011 – April 2019	Board of Directors, National Abortion Federation

Chair, Quality Assessment and Improvement Committee
Chair-Elect, Board of Directors: 2015-2016
Chair, Board of Directors: 2016-2018

Committees/Other Activities

ACOG District XI Legislative Committee (2013)
ACOG Committee on Healthcare for Underserved Women (2015-2019)
Baylor College of Medicine, Department of Ob/Gyn Clinical Competencies Committee
Ben Taub Hospital Ob/Gyn Quality Committee
Ben Taub OB/GYN Peer Review Committee
Houston Endowment's Improving Maternal Health Initiative – Implicit Bias Workgroup
Society of Family Planning Clinical Affairs Subcommittee
Trainer – Merck/Nexplanon contraceptive implant (2011 – 2016)

Certification and Licensure

Medical Licensure:
Texas medical license
Louisiana medical license
California medical license (expired)
Pennsylvania medical license (expired)
DEA license

Specialty Certification:
Certified Diplomate of the American Board of Obstetrics and Gynecology, December 2006

Membership in Professional and Scientific Societies

American College of Obstetricians and Gynecologists, 1999 – present
National Medical Association, 2001 – present
Pennsylvania Medical Society, 2005 – 2007
Pittsburgh Obstetrical and Gynecology Society, 2005 – 2007
Association of Reproductive Health Professionals, 2007 – present
Harris County Medical Society, 2007 – present
Houston Medical Forum, 2009 – present
National Abortion Federation, 2010 – present
Society of Academic Specialists in General Obstetrics and Gynecology, 2013 – present

Honors

National Health Service Corps Scholarship Recipient, 1997
Medical Student Teaching Award, 2001
National Medical Association/NIH Resident Travel Award, 2001
Fulbright and Jaworski Faculty Excellence Award in Training and Evaluation, 2012

Languages Spoken

English
Spanish

Publications

Schutt-Aine A, Crabtree D, Peck M and Levy JS. R1022: 34-year-old G2P2 Caucasian female who desires contraception [Internet]. Newtown Square, PA: CaseNetwork; 2015. http://cases.casenetwork.com.

Contraceptive Procedures
Beasley A and Schutt-Ainé A. Obstet Gynecol Clin North Am. 2013 Dec;40(4):697-729.

Schutt-Aine AI and Timmins AE (2013). Sexual Assault Examination. In EF Reichman (Ed.), Emergency Medicine Procedures (Second Edition). New York: McGraw Hill Education.

Linares AC and Schutt-Aine, AI (2011). Contraception. In R. Rakel and D.Rakel (Eds.), Textbook of Family Medicine (Eighth Edition). Philadelphia: Saunders.

Invited Presenter/Panelist

"What do women need and want with respect to contraception after medical abortion?" – Gynuity Health Projects Conference, Contraception after Medical Abortion: Evidence-based Practice to Meet Women's Needs; Santa Monica, CA; March 2016

"Real World Systems Change" – Physicians for Reproductive Health Alumni Professional Development Summit; Washington, DC; May 2016

"Métodos y esquemas medicamentosos para la interrupción lega del embarazo (ILE)" – Gynuity Health Projects and Corporación Miles Conference, Uso de Mifepristona y Misoprostol en la Ginecología y Obstetricia; Santiago, Chile; August 2017.

"In Pursuit of Healthcare Equality, The Healthcare Crisis for Women in Texas: Maternal Mortality and Other Medical Issues" – Anti-Defamation League Women's Initiative Breakfast; Houston, TX; March 2018

Keynote Address – ACLU of Texas Reproductive Freedom in Action Annual Conference; April 2018

EXHIBIT B

Planned Parenthood Center for Choice ("PPCFC")
Policy in Response to Texas Executive Order GA 09
Relating to Hospital Capacity During the COVID-19 Disaster

PURPOSE

In light of the global pandemic of COVID-19, Governor Abbott signed Executive Order ("EO") GA 09 on March 22, 2020, attached, which is in effect until 11:59 p.m. on April 21, 2020. EO GA 09 directs "all licensed health care professionals and all licensed health care facilities" to "postpone all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician." EO GA 09 goes on to state that this prohibition does not apply to "any procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID- 19 disaster."

POLICY

To comply with EO GA 09, PPCFC hereby establishes the following policies which shall remain in effect until rescinded or modified:

1. Surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician, and which would deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster, are not to be scheduled while this policy is in effect.

2. Physicians shall determine on a case-by-case basis whether a procedure that would deplete hospital capacity or personal protective equipment needed to cope with COVID-19 can be delayed without risk for serious adverse medical consequences or death.

3. PPCFC's physicians have made the determination that abortion is a time-sensitive service and an essential component of comprehensive care, for which a delay of 30 days, or even less, increases the risks to patients, or make abortion completely inaccessible, and that such delay in accessing or inability to access an abortion exposes patients to risk of a serious adverse medical consequence.

4. In making this determination, PPCFC's physicians considered or will consider the following:

a. The purpose and text of EO GA 09, namely: concern for "a shortage of hospital capacity or personal protective equipment" that could "hinder efforts to cope with the COVID-19 disaster."

b. The stated 30-day duration of a the delay, taking into account the Ambulatory Surgery Center Association's "COVID-19: Guidance for ASCs for Necessary Surgery," issued March 18, 2020, which states that consideration of whether delay of a surgery is appropriate must account for risk to the patient of delay, "including the expectation that a delay of 6–8 weeks or more may be required to emerge from an environment in which COVID-19 is less prevalent."

c. The fact that pregnancy has a duration of approximately forty weeks, as measured from the first day of a woman's last menstrual period (LMP) and that most abortions are banned in Texas beginning at 20 weeks gestation. Tex. Health & Safety Code § 171.044.

d. The fact that, while abortion is an extremely safe medical procedure, delay increases the risk to the health of the patient. *See, e.g.,* Nat'l Acads. of Scis. Eng'g & Med., The Safety & Quality of Abortion Care in the United States at 77-78, 162-63 (2018). Delay is of particular concern during the COVID-19 crisis, given guidance from the Center for Disease Control ("CDC") and American College of Obstetricians and Gynecologists ("ACOG") that pregnant women may be at heightened risk of severe illness, morbidity, or mortality from viral respiratory infections such as COVID-19.[1]

e. The Joint Statement by the American College of Obstetricians and Gynecologists ("ACOG"), the American Association of Gynecologic Laparoscopists, *et al.*, on Elective Surgeries[2], issued March 16, 2020, which states that "Obstetric and gynecologic procedures for which a delay will negatively affect patient health and safety should not be delayed. This includes gynecologic procedures and procedures related to pregnancy for which delay would harm patient health. Obstetrician–

[1] Available at https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/03/novel-coronavirus-2019 and https://www.cdc.gov/coronavirus/2019-ncov/hcp/pregnant-women-faq.html

[2] Available at https://www.acog.org/news/news-releases/2020/03/joint-statement-on-elective-surgeries

gynecologists and other health care practitioners should be aware of the unintended impact that policies responding to COVID-19 may have, including limiting access to time-sensitive obstetric and gynecological procedures."

f. The Joint Statement by the ACOG, the American Board of Obstetrics & Gynecology, *et al.,* on Abortion Access During the COVID-19 Outbreak[3], issued March 18, 2020, which states that to "the extent that hospital systems or ambulatory surgical facilities are categorizing procedures that can be delayed during the COVID-19 pandemic, abortion should not be categorized as such a procedure" because it "is an essential component of comprehensive health care" and "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks [to patients] or potentially make it completely inaccessible."

3. All procedures which cannot be reasonably delayed and thus which *are* scheduled and performed, in accordance with the above considerations and in compliance with EO GA 09, shall be performed while making every effort to conserve PPE and to reduce the possibility of spread and transmission of COVID-19.

[3] Available at https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak

EXHIBIT C

March 23, 2020

Health Care Professionals and Facilities, Including Abortion Providers, Must Immediately Stop All Medically Unnecessary Surgeries and Procedures to Preserve Resources to Fight COVID-19 Pandemic

Texas Attorney General Ken Paxton today warned all licensed health care professionals and all licensed health care facilities, including abortion providers, that, pursuant to Executive Order GA 09 issued by Gov. Greg Abbott, they must postpone all surgeries and procedures that are not immediately medically necessary.

On Saturday, Gov. Abbott issued an executive order that "all licensed health care professionals and all licensed health care facilities shall postpone all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician." This prohibition applies throughout the State and to all surgeries and procedures that are not immediately medically necessary, including routine dermatological, ophthalmological, and dental procedures, as well as most scheduled healthcare procedures that are not immediately medically necessary such as orthopedic surgeries or any type of abortion that is not medically necessary to preserve the life or health of the mother.

The COVID-19 pandemic has increased demands for hospital beds and has created a shortage of personal protective equipment needed to protect health care professionals and stop transmission of the virus. Postponing surgeries and procedures that are not immediately medically necessary will ensure that hospital beds are available for those suffering from COVID-19 and that PPEs are available for health care professionals. Failure to comply with an executive order issued by the governor related to the COVID-19 disaster can result in penalties of up to $1,000 or 180 days of jail time.

> **"We must work together as Texans to stop the spread of COVID-19 and ensure that our health care professionals and facilities have all the resources they need to fight the virus at this time," said Attorney General Paxton. "No one is exempt from the governor's executive order on medically unnecessary surgeries and procedures, including abortion providers. Those who violate the governor's order will be met with the full force of the law."**

For information on the spread or treatment of Coronavirus (COVID-19), please visit the Texas Department of State Health Services (https://dshs.texas.gov/coronavirus/) website.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, et al., Plaintiffs, v. GREG ABBOTT, in his official capacity as Governor of Texas, et al., Defendants.	No. 1:20-cv-00323-LY

DECLARATION OF JOSHUA SHARFSTEIN, M.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Joshua Sharfstein, M.D., declare as follows:

1. I am Professor of the Practice in Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health.

2. I am offering this declaration on my own behalf and not on behalf of Johns Hopkins University.

3. Prior to my current position, I served as Secretary of the Maryland Department of Health and Mental Hygiene (including during the Ebola pandemic in 2014), the Acting Commissioner and then the Principal Deputy Commissioner of the U.S. Food and Drug Administration (including during the H1N1 Flu pandemic of 2009), and Commissioner of Health for the City of Baltimore. I have been elected as a member of the National Institute of Medicine and the National Academy of Public Administration. My complete curriculum vitae is attached as Exhibit A.

4. My areas of teaching and research include public health crisis and response, healthcare payment, and the opioid epidemic. I teach a class entitled "Crisis and Response in Public

Health Policy and Practice" and am the author of the Public Health Crisis Survival Guide: Leadership and Management in Trying Times, from Oxford University Press.

5. I am closely following the COVID-19 pandemic. I have written articles about the pandemic in the *Journal of the American Medical Association, USA Today,* and the *New York Times*.

6. I understand that as part of its efforts to conserve personal protective equipment and hospital resources, Texas has issued an executive order barring "all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician," with an exception for surgeries or procedures that "would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster."

7. I further understand that Texas state officials have interpreted this executive order to prohibit most or all abortion services in the state, and that if a patient is not able to obtain an abortion in Texas while this prohibition remains in effect, they will be forced to either remain pregnant for the duration of the order or travel to another state to attempt to obtain an abortion.

8. Delaying non-essential procedures is a responsible act by public health officials and the healthcare system as a mitigation measure during a public health crisis. However, multiple medical professional organizations,[1] led by the American College of Obstetricians and Gynecologists ("ACOG"), have stated that

[1] These include: the American Association of Gynecologic Laparoscopists, the American Gynecological & Obstetrical Society, the American Society for Reproductive Medicine, the Society for Academic Specialists in General Obstetrics and Gynecology, the Society of Family Planning, and the Society for Maternal-Fetal Medicine.

> Abortion is an essential component of comprehensive health care. It is also a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks or potentially make it completely inaccessible. The consequences of being unable to obtain an abortion profoundly impact a person's life, health, and well-being.

Joint Statement on Abortion Access During the COVID-19 Outbreak, ACOG (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak. If Texas is leaving to physicians the determination of whether a procedure can be delayed without risk of serious adverse medical consequences, it does not make sense from a public health perspective to categorically exclude abortion services from this area of clinical judgment.

9. I am concerned that stopping abortion care will unnecessarily complicate the response to the coronavirus pandemic and, indeed, may worsen the public health crisis for three reasons.

10. First, if patients travel to attempt to obtain an abortion in another state, they will expose themselves and others they come in contact with to an increased risk of COVID-19 infection.

11. Second, I have reviewed the declaration of Dr. Schutt-Aine (Decl. of Anne Schutt-Aine, M.D., in Supp. of Pls.' Mot. for TRO & Prelim. Inj., attached as Ex. 7 to Pls.' Mot. for TRO & Prelim. Inj., ECF No. 7-7) and understand from that declaration that if patients are delayed for weeks or more in obtaining an abortion, some will be required to have a two-day procedure instead of a one-day procedure, or a procedural abortion instead of a medication abortion, and that either of these changes results in the use of more personal protective equipment.

12. Third, there is concern that coronavirus infection is more severe in pregnant women. ACOG has stated,

> Currently available data on COVID-19 does not indicate that pregnant women are at increased risk. However, pregnant women are known to be at greater risk of severe

> morbidity and mortality from other respiratory infections such as influenza and SARS-CoV. As such, pregnant women should be considered an at-risk population for COVID-19.

Practice Advisory: Novel Coronavirus 2019 (COVID-19), ACOG (last updated Mar. 13, 2020), https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/03/novel-coronavirus-2019. Delaying a woman from being able to access abortion services may increase the risk for a severe infection that places her and the healthcare system at greater risk.

13. I understand that state officials are taking the position that prohibiting most or all abortion services in the state for some period of time is acceptable because services may be resumed in three weeks absent additional action. Given the trajectory of the pandemic, it is highly unlikely that the United States or Texas will be in a substantially better position in three weeks. The White House has made recommendations for social distancing to be in place until at least April 30. With respect to personal protective equipment, the Centers for Disease Control and Prevention ("CDC") has stated that "shortfalls may be anticipated to continue for the next 3–4 months." *Healthcare Supply of Personal Protective Equipment*, CDC, Nat'l Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases (last reviewed Mar. 14, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/healthcare-supply-ppe.html. It is thus foreseeable that the state will have no basis to change its position in three weeks, which will exacerbate the unintended consequences mentioned above.

14. Texas has other public health measures available that are calculated to be more effective than prohibiting abortion, such as imposing more stringent social distancing measures, which many other states have done and which are showing results in reducing the number of coronavirus infections.

15. As another alternative to the current approach, Texas could take steps to assure that all healthcare providers, including providers of abortion services, have specific plans to reduce spread of coronavirus infection.

16. These alternative steps would accomplish the goals of the state in the coronavirus pandemic, unlike the policy at issue in this case.

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

Joshua Sharfstein, M.D.

Executed on: April 2, 2020

EXHIBIT A

December 2019

CURRICULUM VITAE

Joshua M. Sharfstein, M.D.

PERSONAL DATA

EDUCATION AND TRAINING

2001	Fellowship in General Academic Pediatrics Boston University School of Medicine Boston, MA
1999	Boston Combined Residency Program in Pediatrics Boston Children's Hospital and Boston Medical Center Boston, MA
1996	M.D. Harvard Medical School Boston, MA
1991	A.B., Social Studies, *summa cum laude* Harvard College Cambridge, MA

Medical Licensure

2001-	Maryland
2001-	District of Columbia (inactive)
1997-2001	Massachusetts

Board Certification

2016	Passed Maintenance of Certification exam
2006	Recertification in Pediatrics by American Board of Pediatrics
1999	Certification in Pediatrics by American Board of Pediatrics

PROFESSIONAL EXPERIENCE

1/15 - Faculty, Johns Hopkins Bloomberg School of Public Health

Professor of the Practice in the Department of Health Policy and Management. Associate Dean for Public Health Practice and Training (1/15-3/18). Inaugural Director, Bloomberg American Health Initiative (11/15-). Vice Dean for Public Health Practice and Community Engagement (3/18-)

1/11 - 12/14 Secretary, Maryland Department of Health and Mental Hygiene

Appointed by Governor Martin O'Malley and confirmed by Maryland State Senate. Co-chair of Maryland Health Care Quality & Cost Council and chair of Maryland Health Benefit Exchange.

3/09 - 1/11 Acting Commissioner (until 6/09) and then Principal Deputy Commissioner, U.S. Food and Drug Administration

Appointed by President Barack Obama to second-highest ranking position in the agency.

12/05 - 3/09 Commissioner of Health, Baltimore City

Appointed by Mayor Martin O'Malley and re-appointed by Mayor Sheila Dixon, with confirmation by City Council, to lead the oldest, continuously operating health department in the United States. Chair of Baltimore Substance Abuse Systems, Inc., Baltimore Healthcare Access, Inc., Baltimore City Healthy Start, Inc., and Baltimore Animal Rescue and Care Shelter, Inc.

7/01 - 12/05 Minority Professional Staff and Health Policy Advisor, Government Reform Committee, U.S. House of Representatives.

For Congressman Henry A. Waxman.

PROFESSIONAL ACTIVITIES

Society Membership and Leadership

- Elected Fellow, Institute of Medicine, 2014-Present
- Elected Fellow, National Academy of Public Administration, 2013-Present
- Fellow, American Academy of Pediatrics, 2001-Present

Advisory Panels

- Member, Committee of Science, Technology, and Law of the National Academies of Science, Engineering, and Medicine.
- Co-Chair, Population Health Roundtable, National Academies of Science, Engineering and Medicine, 1/18-
- Chair, Advisory board for Network for Public Health Law, 6/2017- 2/2019.
- Member, Board on Population Health and Public Health Practice, Institute of Medicine, 2007-2009 and 2013-2019.
- Member, Health Information Technology Policy Advisory Committee, U.S. Department of Health and Human Services, 2012-2014.
- Member, Advisory Board, Leadership for Healthy Communities, 2007-2009

EDITORIAL ACTIVITIES

Peer Review Activities (recent)

- Journal of the American Medical Association
- New England Journal of Medicine
- JAMA Internal Medicine
- JAMA Pediatrics
- Pediatrics

Editorial Board Membership

- Journal of the American Medical Association, 2011- .
    - Co-editor of Special Issue on Health Policy, November 13, 2013.
- Public Health Reports, Contributing Editor for Local Acts, 2007-2009

Other Editorial Activity

- Guest Editor, JAMA Internal Medicine, October 2014 issue on medical devices

HONORS AND AWARDS

2018 Advising, Mentoring, Teaching Recognition Award, Johns Hopkins Bloomberg School of Public Health

2014	Heart Healthy, Stroke Free Award, National Forum for Heart Disease & Stroke Prevention
2013	Circle of Commendation Award, Consumer Product Safety Commission NARAL Pro-Choice Maryland Leadership Award
2008	Public Official of the Year, Governing Magazine
1999	Alpha Omega Alpha, Boston University School of Medicine
1996	Rose Seegal Award for Research, Community Service Award, Robert H. Ebert Prize in Primary Care, Harvard Medical School
1994	Jay S. Drotman Memorial Award, American Public Health Association
1991	Phi Beta Kappa, Thomas Temple Hoopes Prize, Frederick Sheldon Traveling Fellowship, Harvard College

Named Lectureships

February 6, 2019	Ernest M. Haddad Lecture. Massachusetts General Hospital Internal Medicine Grand Rounds. *Mission Impossible? Asking Health Care to Advance the Health of the Population*
October 25, 2019	C. Everett Koop Distinguished Lecture, C. Everett Koop Institute, Dartmouth College. *The Politics of Public Health: The Case of the Opioid Epidemic.*
May 24, 2018	Leon Kassel Lecture, Sinai Hospital. *The U.S. Opioid Epidemic: Past, Present, and Future.*
November 15, 2016	John C. Robinson Lecture, Massachusetts General Hospital for Children. *Will Changes in Healthcare Mean Better Health for Children?*
April 18, 2014	Charles C. Leighton MD Memorial Lecture, Leonard Davis Institute at the University of Pennsylvania. *Maryland's Unique Hospital Payment Policy.*
October 15, 2013	Seidman Lecture, Harvard Medical School. *Lashed to the Mast: Navigating through Health CarePolicy, Politics, and Reform in 2014 and Beyond.*
June 26, 2013	Hunt Lectureship, Maryland State Medical Society. *History of the FDA.*
October 4, 2012	Hirsch Lecture in Health Law and Policy, George Washington School of Public Health. *Aligning Health Care with Health.*

April 26, 2012	Albert J. Himelfarb Lecture, Sinai Hospital Department of Medicine, *Health Care 2015 -- and How Do We Get There?*
April 27, 2011	Paul A. Harper Lecture, Johns Hopkins Bloomberg School of Public Health, *Advocacy for Children*
October 5, 2010	Francis S. Balassone Lecture, University of Maryland School of Pharmacy. *Regulation at FDA*
April 24, 2010	Theodore E. Woodward Annual Lecture, University of Maryland School of Medicine, *FDA, Clinical Medicine, and Public Health*
August 21, 2008	Moira J. Whitehead Memorial Lecture, Children's Hospital of Pittsburgh. *From Bedside to Policy: Pediatrics and Public Health*

PUBLICATIONS

Journal Articles: **Peer Reviewed Studies and Reviews**

1. Heyward J, Olson L, Sharfstein JM, Stuart EA, Lurie P, Alexander GC. Evaluation of the Extended-Release/Long-Acting Opioid Prescribing Risk Evaluation and Mitigation Strategy Program by the US Food and Drug Administration: A Review. JAMA Intern Med. 2019 Dec 30. [Epub ahead of print]

2. Pérez AV, Trujillo AJ, Mejia AE, Contreras JD, Sharfstein JM. Evaluating the centralized purchasing policy for the treatment of hepatitis C: The Colombian CASE. Pharmacol Res Perspect. 2019 Dec 10;7(6):e00552.

3. Wallace M, Sharfstein J, Lessler J. Performance and Priorities: A Cross-sectional Study of Local Health Department Approaches to Essential Public Health Services. Public Health Rep. 2020 Jan;135(1):97-106.

4. Rollman JE, Heyward J, Olson L, Lurie P, Sharfstein J, Alexander GC. Assessment of the FDA Risk Evaluation and Mitigation Strategy for Transmucosal Immediate-Release Fentanyl Products. *Journal of the American Medical Association*. 2019 Feb 19;321(7):676-685.

5. Wallace M, Sharfstein JM, Kaminsky J, Lessler J. Comparison of US County-Level Public Health Performance Rankings With County Cluster and National Rankings: Assessment Based on Prevalence Rates of Smoking and Obesity and Motor Vehicle Crash Death Rates. *JAMA Network Open.* 2019 Jan 4;2(1):e186816.

6. Xu T, Klein EY, Zhou M, Lowenthal J, Sharfstein JM, Peterson SM. Emergency Department Utilization Among the Uninsured During Insurance Expansion in Maryland. *Ann Emerg Med.* 2018 Aug;72(2):156-165.

7. Horon IL, Singal P, Fowler DR, Sharfstein JM. Standard Death Certificates Versus Enhanced Surveillance to Identify Heroin Overdose-Related Deaths. *Am J Public Health.* 2018 Jun;108(6):777-781.

8. Alexander GC, Ballreich J, Socal MP, Karmarkar T, Trujillo A, Greene J, Sharfstein J, Anderson G. Reducing branded prescription drug prices: A review of policy options. *Pharmacotherapy*. 2017 Aug 14. [Epub ahead of print]

9. Tschudy MM, Sharfstein J, Matsui E, Barnes CS, Chacker S, Codina R, Cohn JR, Sandel M, Wedner HJ. Something new in the air: Paying for community-based environmental approaches to asthma prevention and control. *J Allergy Clin Immunol.* 2017 Feb 10. pii: S0091-6749(17)30223-3.

10. Rebbert-Franklin K, Haas E, Singal P, Cherico-Hsii S, Baier M, Collins K, Webner K, Sharfstein J. Development of Maryland Local Overdose Fatality Review Teams: A Localized, Interdisciplinary Approach to Combat the Growing Problem of Drug Overdose Deaths. *Health Promot Pract*. 2016 Jul;17(4):596-600.

11. Horrocks D, Kinzer D, Afzal S, Alpern J, Sharfstein JM. The Adequacy of Individual Hospital Data to Identify High Utilizers and Assess Community Health. *JAMA Internal Medicine*. 2016 Jun 1;176(6):856-8. Research letter.

12. Cherico-Hsii S, Bankoski A, Singal P, Horon I, Beane E, Casey M, Rebbert-Franklin K, Sharfstein J. Sharing Overdose Data Across State Agencies to Inform Public Health Strategies: A Case Study. *Public Health Rep*. 2016 Mar-Apr;131(2):258-63..

13. Hussein CA, Luckner M, Samson R, Matsuoka K, Mann DA, Rekhi R, Richardson E, Hurson JA, Reece EA, Sharfstein JM. Working with communities to achieve health equity in Maryland's five health enterprise zones. *Journal of Health Care for the Poor and Underserved* 2014; 25(1 Suppl): 4-10.

14. Schwartz RP, Gryczynski J, O'Grady KE, Sharfstein JM, Warren G, Olsen Y, Mitchell SG, Jaffe JH. Opioid agonist treatments and heroin overdose deaths in Baltimore, Maryland, 1995-2009. *American Journal of Public Health* 2013;103:917-22.

15. Schnitzer, MI, Kaplin DB, Keane VA, Zuckerman B, Sharfstein JM. Giving literacy a shot in the arm. *Public Health Reports* 2008; 123(4): 523-6.

16. O'Keefe, G, Veale L, North M, Goetzinger K, Stewart J, Sharfstein J. A public health response to the implementation of Medicare Part D. *Public Health Reports* 2007; 122(1)101-4.

17. Averbach AR, Lam D, Lam LP, Sharfstein J, Cohen B, Koh H. Smoking behaviours and attitudes among male restaurant workers in Boston's Chinatown: a pilot study. *Tobacco Control* 2002;11 Suppl 2: ii34-7

18. Atkinson KA, Zuckerman B, Sharfstein J, Levin D, Blatt R, Koh H. A public health response to emerging technology: expansion of the Massachusetts newborn screening program. *Public Health Reports* 2001; 116:122-31.

19. Bauchner H, Sharfstein J. Failure to report ethical approval in child health research: review of published papers. *British Medical Journal* 2001;323:318-9.

20. Sharfstein J, Sandel M, Kahn R, Bauchner H. Is child health at risk while families wait for housing vouchers? *American Journal of Public Health* 2001; 91:1191-2.

21. Sharfstein J. Blowing smoke: How cigarette manufacturers argued that nicotine is not addictive. *Tobacco Control* 1999;8:210-213.

22. Sharfstein J. Tackling tobacco or limiting malpractice awards? The campaign contribution priorities of the American Medical Association in the 1996 U.S. Congressional elections. *American Journal of Public Health* 1998; 88: 1233-1236.

23. Sharfstein J and Wise P. Inadequate hepatitis B vaccination of adolescents and adults at an urban community health center. *Journal of the National Medical Association* 1997; 89:86–92.

24. Sharfstein J and Sharfstein SS. Campaign contributions from the American Medical Political Action Committee to members of Congress: For or against the public health? *New England Journal of Medicine*.1994; 330: 32–37. Correction: 332:1450.

Books or Monographs

1. Olsen Y and Sharfstein J. *The Opioid Epidemic: What Everyone Needs to Know.* Oxford: Oxford University Press, 2019.

2. Sharfstein J. *The Public Health Crisis Survival Guide: Leadership and Management in Trying Times*. Oxford: Oxford University Press, 2018.

3. Sharfstein JM, Chrysler D, Bernstein J, Armijos L, Tolosa-Leiv, L, Taylor H, and Rutkow, . (2017, December). Using Electronic Health Data for Community Health:Example Cases and Legal Analysis. Retrieved from http://www.debeaumont.org/EHDforCommunityHealth.

4. Sharfstein J, Gerovich S, Moriarty E, Chin D. An emerging approach to payment reform: All-payer global budgets for large safety-net hospital systems. Commonwealth Fund. August 2017.

5. Emanuel E, Spiro T, Calsyn M, Price C, Altman S, Armstrong S, Colmers C, Cutler D, de Brantes F, Egerman P, Kocher K, Orzag P, Rosenthal M, Selig, J, Sharfstein J, Stern A, Tanden N. *Accountable Care States: the Future of Health Care Cost Control.* Washington: Center For American Progress, August 2014.

6. Sharfstein, J and Sandel M. Editors. *Not Safe at Home: How America's Housing Crisis Threatens the Health of Its Children.* Boston: Boston Medical Center Department of Pediatrics, 1998. Reprinted in *Health Policy & Child Health* 1998; 5(1):1-6. and *Journal of Housing and Community Development* 1998;55(4): 14-24.

7. Torrey EF, Stieber J, Ezekiel R, Wolfe S, Sharfstein J, Noble J and Flynn L. *Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals.* Washington D.C.: Public Citizen and the National Alliance for the Mentally Ill, 1992.

Commentaries and Editorials

1. Sharfstein JM, Olsen Y. How Not to Spend an Opioid Settlement. JAMA. 2020 Mar 17;323(11):1031-1032.

2. Sharfstein JM, Becker SJ, Mello MM. Diagnostic Testing for the Novel Coronavirus. JAMA. 2020 Mar 9. [Epub ahead of print]

3. Sunderji A, Mena KN, Winickoff J, Melinek J, Sharfstein J. Influenza Vaccination and Migration at the US Southern Border. Am J Public Health. 2020 Apr;110(4):466-467. doi: 10.2105/AJPH.2019.305547.

4. Sharfstein JM. Reform at the FDA-In Need of Reform. JAMA. 2020 Jan 14;323(2):123-124.

5. Felix C, Sharfstein JM, Olsen Y. Help Is on the Way: Medicare Coverage of Opioid Treatment Programs. J Am Geriatr Soc. 2019 Dec 11. doi: 10.1111/jgs.16281. [Epub ahead of print]

6. Pytell JD, Sharfstein JM, Olsen Y. Facilitating Methadone Use in Hospitals and Skilled Nursing Facilities. *JAMA Internal Medicine.* 2019 Nov 18.

7. Sharfstein JM. Adolescence: An Opportunity for Population Health. *Milbank Quarterly.* 2019 Nov 6.

8. Sharfstein JM, Olsen Y. Lessons Learned From the Opioid Epidemic. *Journal of the American Medical Association*. 2019 Aug 5. doi: 10.1001/jama.2019.9794. [Epub ahead of print]

9. Kawasaki S, Sharfstein JM. The cost of the opioid epidemic, in context. *American Journal of Managed Care.* 2019 Jul;25(13 Suppl):S241-S242. PubMed PMID: 31361433.

10. Sharfstein JM, Slocum J. Private Equity and Dermatology-First, Do No Harm. *JAMA Dermatology*. 2019 Jul 24.

11. Cohen PA, Sharfstein J. The Opportunity of CBD - Reforming the Law. *New England Journal of Medicine.* 2019 Jul 25;381(4):297-299.

12. Sharfstein JM, Olsen Y. Making Amends for the Opioid Epidemic. *Journal of the American Medical Association*. 2019 Apr 16;321(15):1446-1447.

13. Sharfstein JM. Introduction: State Innovation Models. *Milbank Quarterly*. 2019 Jun;97(2):505. 30957298; PubMed Central PMCID: PMC6554553.

14. Sharfstein JM. The Promise-and Politics-of State Innovation for Health. *Milbank Quarterly*. 2019 Jun;97(2):387-390. doi: 10.1111/1468-0009.12384. Epub 2019 Apr 4.

15. Resnick BA, Morlock L, Diener-West M, Stuart EA, Spencer M, Sharfstein JM. PH WINS and the Future of Public Health Education. *J Public Health Manag Pract.* 2019 Mar/Apr;25 Suppl 2, Public Health Workforce Interests and Needs Survey 2017:S10-S12.

16. Sharfstein JM. Common Ground on Health. *JAMA*. 2018 Dec 25;320(24):2518-2519.

17. Rajagopal S, Barnhill A, Sharfstein JM. The evidence-and acceptability-of taxes on unhealthy foods. *Isr J Health Policy Res*. 2018 Nov 20;7(1):68.

18. Sharfstein JM, Leighton J, Sommer A, MacKenzie EJ. Public Health Rising to the Challenge: The Bloomberg American Health Initiative. *Public Health Rep.* 2018 Nov/Dec;133(1_suppl):3S-4S.

19. Sharfstein J, Santamaria R. Enabling School Success to Improve Community Health. *JAMA.* 2018 Sep 18;320(11):1096.

20. Sharfstein JM. The Fires Are Burning. *Milbank Q.* 2018 Oct 21.

21. Bommersbach T, Borger K, Steverman S, Manderscheid RW, Sharfstein J, Everett A. Behavioral Health, Local Health Department Accreditation, and Public Health 3.0: Leveraging Opportunities for Collaboration. *Am J Public Health.* 2018 Oct;108(10):1334-1340.

22. Sharfstein JM. How Do You Solve a Problem Like Juul? *Milbank Q.* 2018 Sep;96(3):417-420.

23. Sharfstein JM, Stuart EA, Antos J. Global Budgets in Maryland: Assessing Results to Date. JAMA. 2018 Jun 26;319(24):2475-2476.

24. Sharfstein JM. Crises and Population Health. *Milbank Quarterly*. 2018 Apr 13.. [Epub ahead of print].

25. Sharfstein JM. A Health Policy Sonnet. *Milbank Quarterly*. 2018 Mar;96(1):9-12.

26. Green TC, Rich JD, Sharfstein J. Commentary on 'Revisiting the 'paradigm shift' in opioid use: Developments and implications 10 years later'. *Drug Alcohol Rev.* 2018 Apr;37 Suppl 1:S206-S207.

27. Sharfstein JM. A New Year's Wish on Opioids. JAMA. 2018 Feb 13;319(6):537-538.

28. Sharfstein JM, Stuart EA, Antos J. Maryland's All-Payer Health Reform-A Promising Work in Progress. JAMA Intern Med. 2018 Feb 1;178(2):269-270.

29. Sharfstein JM. Common Ground on Responsibility for Health. *Milbank Quarterly*. 2017 Dec;95(4):718-721.

30. Hatef E, Sharfstein JM, Labrique AB. Innovation and Entrepreneurship: Harnessing the Public Health Skill Set in a New Era of Health Reforms and Investment. *J Public Health Manag Pract*. 2017 Oct 24.

31. Sharfstein JM, Gerovich S, Chin D. Global Budgets for Safety-Net Hospitals. *Journal of the American Medical Association.* 2017 Nov 14;318(18):1759-1760.

32. Sharfstein JM. Science and the Trump Administration. *Journal of the American Medical Association*. 2017 Oct 10;318(14):1312-1313

33. Sharfstein JM. Public Health Bundles. *Milbank Quarterly*. 2017 Sep;95(3):474-477.

34. Poku MK, Blum AB, Sharfstein JM. US Hospital Awards and Community Health Improvement. Am J Public Health. 2017 Jul;107(7):1076-1077.

35. Redberg RF, Jacoby AF, Sharfstein JM. Power Morcellators, Postmarketing Surveillance, and the US Food and Drug Administration. *Journal of the American Medical Association*. 2017 Jul 25;318(4):325-326.

36. Sharfstein JM, Silver DL. Relationship Between the American Academy of Pediatrics and Infant Formula Companies. *JAMA Pediatr.* 2017 Jul 1;171(7):613-614.

37. Sharfstein JM. Vaccines and the Trump Administration. *Journal of the American Medical Association*. 2017 Apr 4;317(13):1305-1306.

38. Sharfstein J. Déjà Vu at the FDA. *Milbank Quarterly*. 2017 Jun;95(2):245-248. Epub 2017 Apr 4.

39. Sharfstein JM, Stebbins M. Enhancing Transparency at the US Food and Drug Administration: Moving Beyond the 21st Century Cures Act. *Journal of the American Medical Association*. 2017 Apr 25;317(16):1621-1622.

40. Sharfstein JM. The Opioid Crisis From Research to Practice. *Milbank Quarterly.* 2017 Mar;95(1):24-27.

41. Hughes HK, Landa MM, Sharfstein JM. Marketing Claims for Infant Formula: The Need for Evidence. *JAMA Pediatrics.* 2017 Feb 1;171(2):105-106.

42. Sharfstein JM. Violent Injury as a Preventable Condition. *Milbank Quarterly.* 2016 Dec;94(4):708-711.

43. Conti RM, Gee RE, Sharfstein JM. Pharmaceuticals and Public Health. *Journal of the American Medical Association*. 2016 Nov 22;316(20):2083-2084.

44. Sharfstein JM. Banishing "Stakeholders." *Milbank Quarterly*. 2016 Sep;94(3):476-9.

45. Poku MK, Hellmann DB, Sharfstein JM. Hospital Accreditation and Community Health. *American Journal of Medicine.* 2016 Aug 1. pii: S0002-9343(16)30743-4.

46. Sharfstein JM. Global Budgets for Rural Hospitals. *Milbank Quarterly.* 2016 Jun;94(2):255-9.

47. Saloner B, Sharfstein J. A Stronger Treatment System for Opioid Use Disorders. *Journal of the American Medical Association*. 2016 May 24-31;315(20):2165-6

48. Sharfstein JM, Greene J. Promise and Peril for Generic Drugs. *JAMA Internal Medicin*e 2016 Jun 1;176(6):733-4.

49. Baciu A, Sharfstein JM. Population Health Case Reports: From Clinic to Community. *Journal of the American Medical Association*. 2016 Jun 28;315(24):2663-4.

50. Kapoor A, Sharfstein JM. Breaking the gridlock: Regulation of dietary supplements in the United States. *Drug Test Anal*. 2016 Mar-Apr;8(3-4):424-30.

51. Sharfstein JM. Rethinking Science and Politics. *Milbank Q*. 2016 Mar;94(1):39-42. doi: 10.1111/1468-0009.12177.

52. Sharfstein JM, Psaty BM. Evaluation of the Cardiovascular Risk of Naltrexone-Bupropion: A Study Interrupted. *Journal of the American Medical Association*. 2016 Mar 8;315(10):984-6.

53. Greene JA, Anderson G, Sharfstein JM. Role of the FDA in Affordability of Off-Patent Pharmaceuticals. *Journal of the American Medical Association*. 2016 Feb 2;315(5):461-2.

54. Sharfstein JM. Accountability for Health. *Milbank Quarterly* 2015; 93(4):675-8.

55. Patel A, Rajkumar R, Colmers JM, Kinzer D, Conway PH, Sharfstein JM. Maryland's Global Hospital Budgets--Preliminary Results from an All-Payer Model. *New England Journal of Medicine* 2015;373(20):1899-901.

56. Sharfstein JM, Charo A. The Promotion of Medical Products in the 21st Century: Off-label Marketing and First Amendment Concerns. *Journal of the American Medical Association* 2015;314(17):1795-6.

57. Sharfstein JM. Public Health and the First Amendment. *Milbank Quarterly* 2015;93(3):459-62.

58. Hwang A, Sharfstein JM, Koller CF. State Leadership in Health Care Transformation: Red and Blue. *Journal of the American Medical Association* 2015; 314:349-50.

59. Sharfstein JM, Kesselheim AS. The Safety of Prescription Drugs. *Journal of the American Medical Association* 2015;314:233-4.

60. Sharfstein JM. A Spotlight on Sunscreen Regulation. *New England Journal of Medicin*e. 2015 Jul 9;373(2):101-3.

61. Sharfstein JM. Electronic cigarettes: gateway to understanding the FDA? *Milbank Quarterly*. 2015 Jun;93(2):251-4.

62. Sharfstein JM. Using healthcare data to track and improve public health. *Journal of the American Medical Association*. 2015 May 26;313(20):2012-3.

63. Sharfstein JM, Kinzer D, Colmers JM. An Update on Maryland's All-Payer Approach to Reforming the Delivery of Health Care. *JAMA Internal Medicine* 2015; 175:1083-4.

64. Wen LS, Sharfstein JM. Unrest in Baltimore: The Role of Public Health. *Journal of the American Medical Association* 2015;313:2425-6.

65. Sharfstein JM. Of mouse and measles. *Journal of the American Medical Association*. 2015 Apr 21;313(15):1504-5.

66. Gold D, Newman-Toker DE, Sharfstein JM. Neurology and the Affordable Care Act. *JAMA Neurology* 2015; 72(6):623-4.

67. Sharfstein JM. Dear health care lobbyists . . . *Milbank Quarterly*. 2015; 93(1):15-8.

68. Wong WF, LaVeist TA, Sharfstein JM. Achieving Health Equity by Design. *Journal of the American Medical Association*. 2015; 313(14):1417-8.

69. Sharfstein JM. On fear, distrust, and Ebola. *Journal of the American Medical Association*. 2015 Feb 24;313(8):784.

70. Sharfstein J. FDA regulation of laboratory-developed diagnostic tests: protect the public, advance the science. *Journal of the American Medical Association*. 2015 Feb 17;313: 667-8.

71. Sharfstein JM. Health care and poverty. *Journal of the American Medical Association*. 2014 Dec 3;312(21):2200-1.

72. Sharfstein J. The strange career of population health. *Milbank Quarterly* 2014; 92: 640-643.

73. Dietrich E, Sharfstein J. Improving medical device regulation: a work in progress. *JAMA Internal Medicine* 2014;174(11):1779-1780.

74. Sharfstein J. Speaking with Doctors in Restaurants. *Milbank Quarterly* 2014; 92: 422-5.

75. Sharfstein J. On Working for Henry Waxman. *Milbank Quarterly* 2014; 92: 186-190.

76. Olsen Y, Sharfstein J. Chronic Pain, Addiction, and Zohydro. *New England Journal of Medicine* 2014; 370: 2061-2063.

77. Olsen Y, Sharfstein J. Confronting the stigma of opioid use disorder—and its treatment. *Journal of the American Medical Association* 2014; 311: 1393-4.

78. Rajkumar R, Patel A, Murphy K, Colmers JM, Blum JD, Conway PH, Sharfstein JM. Maryland's All-Payer Approach to Delivery-System Reform. *New England Journal of Medicine* 2014; 370(6) 493-5.

79. Sharfstein J, Fontanarosa PB, Bauchner H. Critical issues in US health care: health care on the edge. *Journal of the American Medical Association* 2013; 310:1945-6.

80. Reece EA, Brown AG, Sharfstein JM. New incentive-based programs: Maryland's health disparities initiatives. *Journal of the American Medical Association* 2013; 310:259-60.

81. Steinbrook R, Sharfstein JM. The FDA Safety and Innovation Act. *Journal of the American Medical Association* 2012; Oct 10;308(14):1437-8.

82. Wilson LE, Blythe D, Sharfstein JM. Fungal meningitis from injection of contaminated steroids: a compounding problem. *Journal of the American Medical Association* 2012; 308:2461-2.

83. Emanuel E, Tanden N, Altman S, Armstrong S, Berwick D, de Brantes F, Calsyn M, Chernew M, Colmers J, Cutler D, Daschle T, Egerman P, Kocher B, Milstein A, Oshima Lee E, Podesta JD, Reinhardt U, Rosenthal M, Sharfstein J, Shortell S, Stern A, Orszag PR, Spiro T. A systemic approach to containing health care spending. *New England Journal of Medicine* 2012; 367:949-54.

84. Sharfstein JM. The FDA--a misunderstood agency. *Journal of the American Medical Association* 2011; 306:1250-1.

85. Woodcock A, Sharfstein JM, and Hamburg MA. Regulatory Action on Rosiglitazone by the U.S. Food and Drug Administration. *New England Journal of Medicine* 2010; 363: 1489-1491.

86. Asamoah A and Sharfstein JM. Transparency at the Food and Drug Administration. *New England Journal of Medicine* 2010; 362: 2341-2343.

87. Deyton L, Sharfstein JM, and Hamburg MA. Tobacco Product Regulation – A Public Health Approach. *New England Journal of Medicine* 2010; 362: 1753-1756.

88. Hamburg MA and Sharfstein JM. The FDA as a Public Health Agency. *New England Journal of Medicine* 2009; 360: 2493-2495.

89. Sharfstein JM, North M, Serwint JR. Over the counter but no longer under the radar—pediatric cough and cold medications. *New England Journal of Medicine* 2007; 357: 2321-4.

90. Sharfstein J. Kids first? *Int J Health Serv.* 2000;30(4):763-9.

Selected Other Publications

1. Sharfstein JM, Marx MA. Testing is just the beginning in the battle against Covid-19. *The New York Times.* 30 March 2020. https://www.nytimes.com/2020/03/30/opinion/coronavirus-testing.html

2. Sharfstein J, Nuzzo J, Anderson G. 4 reasons America needs a new coronavirus crisis insurance program based on Medicare. *The USA Today.* 19 March 2020. https://www.usatoday.com/story/opinion/2020/03/19/pass-coronavirus-crisis-insurance-use-medicare-networks-billing-column/2865457001/

3. Alexander GC, Sharfstein J. Opioid Epidemic: Fight addiction and chronic pain together to save lives. *The USA Today.* 25 April 2019. https://www.usatoday.com/story/opinion/2019/04/25/opioid-epidemic-overdose-treat-addiction-pain-management-prescription-drugs-column/3548434002/

4. Bollyky TJ, Kesselheim AS, Sharfstein JM. What Trump should actually do about the high cost of drugs. *The New York Times*. 14 May 2018. https://www.nytimes.com/2018/05/14/opinion/trump-costs-drugs-pricing.html

5. Sharfstein J, Lee J, Conti R. We have a cure for hepatitis C. But the neediest can't afford it. Louisiana wants to change that. Vox. 27 September 2017. https://www.vox.com/science-and-health/2017/9/27/16350562/hepatitis-c-drug-prices-louisiana

6. Sharfstein J. Trump's opioid declaration is meaningless without action. *The USA Today.* 25 August 2017.

7. Sharfstein J, Phillips F. Dirty Buses, Sick Kids. *The New York Times*. 8 January 2016.

8. Sharfstein JM. Flow Resistant caps prevent the rapid ingestion of liquid medicine. *Journal of Pediatrics* 2014; 164: 1242.

9. Mixter S, Yang JX, Sharfstein J. Tuberculosis in Maryland: Global and Historical Perspectives. *Maryland Medicine* 2013; 14: 1.

10. Sharfstein J. The state of breastfeeding in a state. *Breastfeeding Medicine* 2012; 7: 369.

11. Sharfstein J. In sickness and in health: physicians as captains of the ship. *Maryland Medicine* 2011; 12: 13-4.

12. Phillips F and Sharfstein J. A Medicaid provision to repeal. *Washington Post*. 4 March 2007: B8.

13. Story E and Sharfstein J. Needed: 'MCAS' for children's mental health care. *Boston Globe*. 15 April 2001: D4.

14. Sharfstein J. Unhealthy Partnership. *The American Prospect*. January 1-15, 2001: 24-28.

15. Sharfstein J. Folic Acid Antagonists during pregnancy and risk of birth defects. Letter. *New England Journal of Medicine* 2001; 344:933.

16. Sharfstein J, Babl F. Cat scratch disease without cat scratch. *Infectious Diseases in Children* 1999; August: 58.

17. Sharfstein J, Jeffery P and Agrawal D. A case of phenytoin toxicity. *Pediatrics* 1998 Nov;102(5):1223.

18. Sharfstein J. Pfizer Night at Boston Billiards. Letter. *New England Journal of Medicine* 1997; 337(2):134.

19. Sharfstein J, Wise P. Cost-effectiveness of hepatitis B virus immunization. JAMA. 1996 Mar 27;275(12):908; author reply 909.

20. Sharfstein J and Gupta A. Confidentiality of radiologic images. Letter. *Radiology* 1995: 873–4.

Selected Blog Posts

1. Sharfstein J. JAMA Forum: Science and the Trump Administration. 6 September 2017. Available at https://newsatjama.jama.com/2017/09/06/jama-forum-science-and-the-trump-administration/.

2. Sharfstein J. JAMA Forum: After 50 Years, a Leap Backward for Children? 17 May 2017. Available at https://newsatjama.jama.com/2017/05/17/jama-forum-after-50-years-a-leap-backward-for-children/.

3. Sharfstein J. JAMA Forum: Notes on the Presidential Transition. 16 November 2016. Available at https://newsatjama.jama.com/2016/11/16/jama-forum-notes-on-the-presidential-transition/

4. Sharfstein J. JAMA Forum: "Mayor's Night Out" and the Politics of Health. Available at https://newsatjama.jama.com/2016/08/22/jama-forum-mayors-night-out-and-the-politics-of-health/.

5. Sharfstein J. JAMA Forum: The Zika Virus and Abortion Politics. 11 May 2016. Available at https://newsatjama.jama.com/2016/05/11/jama-forum-the-zika-virus-and-abortion-politics/.

6. Sharfstein J. JAMA Forum: Flint, Michigan and the Failure of Public Agencies. 17 February 2016. Available at https://newsatjama.jama.com/2016/02/17/jama-forum-flint-michigan-and-the-failure-of-public-agencies/.

7. Sharfstein J. JAMA Forum: Neonatal Abstinence Syndrome: Deja Vu All Over Again? 21 October 2015. Available at http://newsatjama.jama.com/2015/10/21/neonatal-abstinence-syndrome-deja-vu-all-over-again/.

8. Sharfstein J. JAMA Forum: "Loose Change" for Population Health. Available at https://newsatjama.jama.com/2015/06/24/jama-forum-loose-change-for-population-health/

9. Sharfstein J. JAMA Forum: A global epidemic in plain sight. 25 June 2014 Available at http://newsatjama.jama.com/2014/06/25/jama-forum-a-global-epidemic-in-plain-sight/

10. Sharfstein J. JAMA Forum: Medical boards and the public's health. 10 April 2014. http://newsatjama.jama.com/2014/04/10/jama-forum-hiding-in-plain-sight-medical-boards-and-the-publics-health/

11. Sharfstein J. JAMA Forum: The public health challenge of drug overdose. 22 January 2014. Available at http://newsatjama.jama.com/2014/01/22/jama-forum-the-public-health-challenge-of-drug-overdose/

12. Sharfstein J. JAMA Forum: Behind the curtain of Maryland's health enterprise zone initiative. 7 August 2013. Available at http://newsatjama.jama.com/2013/08/07/jama-forum-behind-the-curtain-of-marylands-health-enterprise-zone-initiative/

13. Sharfstein J. JAMA Forum: Public health regulation as a public process. 22 May 2013. Available at http://newsatjama.jama.com/2013/05/22/jama-forum-public-health-regulation-as-a-public-process/

14. Sharfstein J. JAMA Forum: The State Role in Health Care Innovation, 6 March 2013. Available at http://newsatjama.jama.com/2013/03/06/jama-forum-the-state-role-in-health-care-innovation/

15. Sharfstein, J. JAMA Forum: Implementing the Affordable Care Act. 5 July 2012. Available at http://newsatjama.jama.com/2012/07/05/jama-forum-implementing-the-affordable-care-act-getting-the-job-done/

SELECTED PRACTICE ACTIVITIES

Johns Hopkins Bloomberg School of Public Health

- Supported strategic plans on opioids in Staten Island (2018), West Virginia (2018), and Louisiana (2018).
- Supported launch of Johns Hopkins Baltimore Violence Reduction Collaborative. 2016.
- Developed proposal and advised Baltimore City Health Department for BFRIEND falls prevention initiative. Proposal funded by Robert Wood Johnson Foundation. 2015-2017.
- Advised Baltimore City Public Schools, Baltimore City Health Department, and DC Public Schools on absenteeism project. 2016-2018.
- Advised Rhode Island Health Commissioner on response to opioid epidemic. 2015-Present.
- Led review of teen pregnancy and healthy birth strategy for Baltimore's Promise. 2015.

Maryland Department of Health and Mental Hygiene

- Led the negotiation with the Centers for Medicare & Medicaid Services to establish a new model for hospital payment in Maryland, essentially ending fee-for-service payment across all payers for Maryland residents.
- Established clear public health goals for Maryland through the State Health Improvement Process, which involves 18 local planning coalitions and a website with accessible, local data.
- Oversaw a strategic shift to community-based long-term care, including the merger of several waiver programs, the introduction of consumer choice, and a significant expansion of access to home care.
- Led the consolidation of the Alcohol and Drug Abuse Administration with the Mental Hygiene Administration into the new Behavioral Health Administration, and developed and implemented a more rational financing approach to behavioral and somatic care.
- Led several regulatory initiatives, including a ban on the sale of baby bumper pads and a revised consent form for indoor tanning devices for teenagers.
- Oversaw the building of a new public health laboratory, the reform of the Developmental Disabilities Administration, improvements in state psychiatric facilities, and transformation of the Maryland Board of Physicians.
- Oversaw reports on youth use of candy-flavored tobacco and health care worker-related transmission of the Hepatitis B virus.

Food and Drug Administration

- Led the development of FDA-Track, a performance management system across the agency. The U.S. Department of Health and Human Services recognized FDA-Track with an award for innovation in 2011.
- Led the agency's transparency initiative, which made substantially more information available about the regulatory process.
- Coordinated federal efforts between CDC, FDA, and the Trade and Tax Bureau on caffeinated, alcoholic beverages, leading to a ban on these unsafe products.
- Represented FDA on key public issues including the use of antibiotics in animals, the safety of bisphenol-A, the safety of infant positioners, the labeling of bottled water, the safety of dietary supplements, the *Salmonella* outbreak from contaminated eggs, and drug safety.
- Oversaw reports on integrity in FDA decisionmaking and transparency at the agency.

Baltimore City Health Department

- Developed initiatives that won four model practice awards from the National Association of County and City Health Officers, including:
    - Facilitating the transition to Medicare Part D using an emergency management approach;
    - The Reach and Read Public Health Challenge to promote literacy in pediatric primary care;
    - The Baltimore Buprenorphine Initiative, which expanded access to effective drug treatment and was associated with a substantial reduction in heroin overdoses; and
    - The Fluoride Varnish initiative, which trained and reimbursed pediatric practices for applying fluoride varnish to reduce dental caries.
- Led successful regulatory initiatives to improve reporting for influenza vaccination and ban the sale of lead-tainted children's jewelry.
- Introduced Health Leads programs on the Hopkins, UMBC, and Loyola campuses, which have involved more than 1,000 students volunteering to connect patients to resources at multiple health care sites in the city.
- Oversaw significant progress towards making the city animal shelter a "no-kill" shelter.
- Drafted the city plan on infant mortality that would be implemented and contribute to substantial improvements over time.
- Advocated for and implemented the ban on indoor smoking in bars and restaurants and the ban on transfats in foods.

- Led a successful, national petition calling for the removal of cough-and-cold medications for young children from the market.
- Oversaw reports on heart disease and salt and arsenic contamination at Swann Park.

Congressional Testimony

April 3, 2014	Testimony before the House Oversight and Government Reform Committee, Subcommittee on Economic Growth, Job Creation, and Regulatory Affairs, Subcommittee on Energy Policy, Health Care, and Entitlements, on the Maryland Health Benefit Exchange
December 13, 2012	Testimony before the House Energy and Commerce Committee, Subcommittee on Health, on Implementation of the Affordable Care Act in Maryland
March 17, 2011	Testimony before the Senate Committee on Health, Education, Labor, and Pensions, on the Implementation of the Affordable Care Act in Maryland
September 30, 2010	Testimony before the House Committee on Oversight and Government Reform, Johnson and Johnson's Recall of Children's Tylenol and Other Children's Medicines
September 22, 2010	Testimony before the House Energy and Commerce Committee, Subcommittee on Oversight and Investigations, on the Outbreak of Salmonella in Eggs
July 14, 2010	Testimony before the House Energy and Commerce Committee, Subcommittee on Health, on Antibiotic Resistance and the Use of Antibiotics in Animal Agriculture
May 27, 2010	Testimony before the House Committee on Oversight and Government Reform, Johnson and Johnson's Recall of Children's Tylenol and Other Children's Medicines
May 26, 2010	Testimony before the Senate Special Committee on Aging, Oversight of Dietary Supplements
March 10, 2010	Testimony before the House Energy and Commerce Committee, Subcommittee on Health, on Drug Safety: An Update from FDA.
July 13, 2009	Testimony before the House Committee on Rules on the Preservation of Antibiotics for Medical Treatment Act of 2009
July 8, 2009	Testimony before the House Committee on Oversight and Government Reform, Subcommittee on Oversight and Investigations, on Regulation

	of Bottled Water.
May 21, 2009	Testimony before the House Committee on Appropriations, Subcommittee on Agriculture, Rural Development, Food and Drug Administration, and Related Agencies, on President's FY 2010 Budget Request
May 7, 2009	Testimony before the before the Senate Committee on Appropriations, Subcommittee on Agriculture, Rural Development, Food and Drug Administration, and Related Agencies, on H1N1 Flu Virus
April 30, 2009	Testimony before the House Energy and Commerce Committee, Subcommittee on Health, on H1N1 Flu Virus.

Testimony Before the Maryland General Assembly

I have testified more than 75 times before the Maryland General Assembly on budget and policy matters. Successful legislative initiatives have included:

2007 session	SB 349 Expedited Partner Therapy Pilot Program for Baltimore City
2011 session	HB 166 Maryland Health Benefit Exchange Act
2012 Session	HB 86 Health Improvement and Disparities Reduction Act HB 443 Maryland Health Benefit Exchange Act HB 658 Emergency Plans for Human Services Facilities and Dialysis Centers
2013 Session	HB 228 Maryland Health Progress Act HB 986 Sterile Compounding HB 1009 Regulation of Cosmetic Surgery Centers SB 1057 Regulation of Health Care Staffing Agencies
2014 Session	HB 1510 Establishment of Behavioral Health Administration

TEACHING

1/1/2015-	Professor of the Practice, Department of Health Policy and Management
7/1/2006 - 6/30/2009	Adjunct Assistant Professor, Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health
9/15/2006 - 6/30/2018	Adjunct Professor, Volunteer, Department of Pediatrics, University of Maryland School of Medicine

Advisees

MPH Capstone

1. Marc Rabner. *School Absenteeism and Public Health. 2016*
2. Laura Mandel. *Provider Network Adequacy in Maryland Managed Care Organizations. 2016.*
3. Megan Collins. *Vision for Baltimore - a 3 year program to provide school-based eye care. 2017.*
4. Maria Armijos. *A policy recommendation for antibiotic use in upper respiratory tract infections in Ecuador. 2017.*
5. Madeline Jackson. *Section 1498 and Public Health Access to Specialty Drugs. 2017.*
6. Charlotte Kaye. *Integrating Public Health Programming into Child Welfare Policy in Baltimore City. 2017.*
7. Jenny X. Wen. *Overcoming systemic barriers to opioid use disorder treatment: evidence and recommendations for the National Academy of Medicine, 2018.*
8. Ali Bokhari. *Drug pricing in public health emergencies, 2018.*

Oral Exams

1. Roza Vazin. Health Policy and Management, PhD. 2016.
2. Amber Cox. International Health, PhD. 2016.
3. Megan Wallace. Epidemiology, DrPH. 2016.

Classroom Instruction: Principal Instructor

1. Crisis and Response in Public Health Policy and Practice. 300.650.01. 3nd term. 29 students. 2018-2019.
2. The Opioid Crisis: Problem Solving Seminar. PH 308.615. 1st term. 71 students. 2018-2019.
3. Crisis Response in Public Health Practice: International Perspectives. 302.843.98. Barcelona Institute. 20 students. 2018.
4. Public Health Policy. 300.610. Summer term. 260 students. 2018.
5. The Practice of Public Health Through Vaccine Case Studies: Problem Solving Seminar. 223.630. 4th Term. 33 students. 2017-2018.
6. Crisis and Response in Public Health Policy and Practice. 300.650.01. 2nd term. 38 students. 2017-2018.
7. Crisis Response in Public Health Practice: International Perspectives. 302.843.98. Barcelona Institute. 15 students. 2017.
8. Crisis Response in Public Health Practice: Workshop. Barcelona Institute. Approximately 10 students. 2017.
9. The Opioid Crisis: Problem Solving Seminar. 308.615.81. 62 students. 2017.
10. Crisis and Response in Public Health Policy and Practice. 300.650.01. 2nd term. 33 students. 2016-2017.

11. Crisis Response in Public Health Practice: International Perspectives. 302.843.98. Barcelona Institute. 25 students. 2016.
12. Crisis and Response in Public Health Policy and Practice. 300.650.01. 1st term. 40 students. 2015-2016.

The Crisis and Response in Public Health Policy and Practice (domestic and international) and Opioid Crisis Problem Solving Seminar have received outstanding range evaluations.

RESEARCH GRANT PARTICIPATION

Technical support for data sharing	De Beaumont Foundation	April 2019-March 2020	90.000

Co-Investigator. We are working with principal investigators at the University of Michigan to provide technical support for localities seeking to

Global Budgeting Policy Academy	Robert Wood Johnson Foundation (via Princeton University)	March 1, 2018 - August 1, 2018	30,000

Principal Investigator. We hosted a policy academy and produced a Q and A document for states on global hospital budgeting in rural areas.

Using Healthcare Data in Public Health Practice	De Beaumont Foundation	September 1, 2016 to September 1, 2017	$100,000

Principal Investigator. The purpose of this grant was to develop use cases and legal pathways for public health departments to use healthcare data. This project was a collaboration with the National Public Health Law Network, and the paper was published in December 2017.

Transparency at the U.S. Food and Drug Administration	Laura and John Arnold Foundation	August 8, 2016 to March 31, 2018	$175,583

Principal Investigator. The purpose of this grant was to develop recommendations to improve transparency at the U.S. FDA. I coordinated an academic team including experts from Johns

Hopkins, Harvard, and Yale, and we published a supplement to the Journal of Law, Medicine, and Ethics.

Assessing the Applicability of Global Hospital Budgeting to Large Safety Net Systems	Commonwealth Fund	June 1, 2016 to June 30, 2017	$49,489

Principal Investigator. The purpose of this grant was to develop a report for the Commonwealth Fund on global hospital budgeting for safety net health systems. This report was published in the summer of 2017.

Reforming States Group letter to the New Administration	Milbank Memorial Fund	April 1, 2016 - December 31, 2016	$10,000

Principal Investigator. The purpose of this grant was to help draft a bipartisan letter on opportunities in health policy for the new administration. This letter was sent in the fall of 2016, and the lead members of the Reforming States Group published an article summarizing the letter in the *New England Journal of Medicine*.

Pharmaceutical Pricing	Laura and John Arnold Foundation	2016 - 2019 2019-	*

Investigator. Professor Gerard Anderson is the Principal Investigator on this project. My main role is to develop public health approaches to pharmaceutical pricing. These efforts culminated in a publication in the *Journal of the American Medical Association* and support for Louisiana's subscription model for hepatitis C elimination.

Healthcare Pricing	Laura and John Arnold Foundation	2019-	*

Investigator. Professor Gerard Anderson is the Principal Investigator on this project. My main role is to assist with work on global-budget type arrangements for hospitals and others in the healthcare system.

SCHOOL SERVICE

Committee	**Role**

Committee of the Whole	Member, 2015-
Graduate Medical Education Committee	Chair, 2015-
Practice Integration Committee	Chair, 2015-2019

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE, et al., Plaintiffs, v. GREG ABBOTT, in his official capacity as Governor of Texas, et al., Defendants.	No. 1:20-cv-00323-LY

DECLARATION OF PLAINTIFF ROBIN WALLACE, M.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

I, Robin Wallace, M.D., declare as follows:

1. I am a board-certified family medicine physician, with additional specialty training in family planning, and an M.A.S. in clinical research. I am licensed to practice in Texas. I am a Plaintiff in this case, representing myself and my patients.

2. I am the co-medical director of Southwestern Women's Surgical Center ("Southwestern"), a licensed ambulatory surgical center in Dallas, Texas. Southwestern provides medication abortion through 10 weeks as measured from the first day of the patient's last menstrual period ("LMP") and procedural abortion services through 21.6 weeks LMP. Southwestern does not provide inpatient care, nor is it set up to do so.

3. As co-medical director, my responsibilities include: review and development of clinic protocols, training of all new physician staff, quality assurance review, and representing the medical staff on the administrative management team and governing board. In addition to my other

responsibilities as co-medical director, I also personally provide abortion care to patients through 21.6 weeks LMP.

4. I submit this declaration in support of Plaintiffs' motion for a temporary restraining order followed by a preliminary injunction, which seeks to enjoin Executive Order No. GA-09 (the "Executive Order"), as interpreted by the Texas Attorney General to ban all previability abortion procedures in the state except where immediately necessary to protect the life or health of a pregnant person. I have reviewed the Executive Order and a press release by the Texas Attorney General interpreting it.

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

The Executive Order and Threatened Enforcement

6. On March 22, 2020, Texas Governor Greg Abbott issued the Executive Order, relating to hospital capacity during the COVID-19 pandemic. That order is in effect until 11:59 p.m. on April 21, 2020, although it may be extended. It directs "all licensed health care professionals and all licensed health care facilities" to "postpone all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician." *Id.* at 1. The Executive Order states that this prohibition does not apply to "any procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not

deplete the hospital capacity or the personal protective equipment ["PPE"] needed to cope with the COVID-19 disaster." *Id.*

7. Southwestern understands the term PPE to refer to surgical masks, N95 respirators (a face covering designed to block at least 95 percent of very small test particles), sterile and non-sterile gloves, disposable protective eyewear, disposable gowns, and disposable shoe covers. The services Southwestern provides do not involve significant amounts of PPE or deplete PPE.

8. On Monday, March 23, 2020, the Attorney General issued a press release interpreting the Executive Order, titled "Health Care Professionals and Facilities, Including Abortion Providers, Must Immediately Stop All Medically Unnecessary Surgeries and Procedures to Preserve Resources to Fight COVID-19 Pandemic." The press release states that the Executive Order applies to "all surgeries and procedures that are not immediately medically necessary," including "most scheduled healthcare procedures that are not immediately medically necessary such as orthopedic surgeries or any type of abortion that is not medically necessary to preserve the life or health of the mother." The release invokes the order's application to abortion providers multiple times. It states that a "[f]ailure to comply with an executive order issued by the governor related to the COVID-19 disaster can result in penalties of up to $1,000 or 180 days of jail time" and warns that "[t]hose who violate the governor's order will be met with the full force of the law."

9. Southwestern is uncertain as to the scope of the Executive Order and the subsequent press release by the Attorney General, and, as a result, largely stopped seeing patients on March 23, 2020. The clinic has cancelled approximately 225 appointments for the last two days, March 23 and March 24. Unless we obtain immediate relief, we intend to continue canceling appointments.

10. The window during which a patient can obtain an abortion in Texas is limited. Pregnancy is generally forty weeks in duration, but Texas prohibits abortion after twenty-two weeks LMP except in very narrow circumstances. See Tex. Health & Safety Code § 171.044.

Southwestern's Efforts to Prevent COVID-19 Spread and Conserve Needed Resources

11. Southwestern is committed to doing its part to minimize spread of COVID-19 and to otherwise help ensure that our public health system has sufficient resources to meet the challenge of responding to a potential surge of illness.

12. Neither medication nor procedural abortion requires extensive PPE or otherwise would deplete PPE. In fact, for medication abortion, providing patients with the medication does not require the use of any PPE. Based on Southwestern's patient load, in an average week, we use the following PPE: a few boxes of non-sterile gloves; approximately 15 pairs of sterile gloves for procedures after 15 weeks LMP; approximately 15 gowns; around 24 pairs of shoe coverings per day; and a handful of simple surgical masks and reusable eyewear.

13. Since the COVID-19 outbreak, and prior to the Executive Order, Southwestern took extensive steps to protect patients and staff and minimize the use of PPE. For example, we have been screening our patients and staff for COVID-19; we have cancelled trainings for medical students, residents, and fellows; and have begun restricting the use of new surgical masks and gowns.

Harms Caused by the Executive Order and the Attorney General's Interpretation of It

14. Southwestern reasonably fears the Attorney General's threat of enforcement, given that the Attorney General may understand the Executive Order to prohibit procedural abortions that Southwestern's physicians have determined are necessary to "correct a serious medical condition of … a patient who without immediate performance of the surgery or procedure would

be at risk for serious adverse medical consequences or death, as determined by the patient's physician," as permitted by the Executive Order. It also reasonably fears that the Attorney General will understand the order to prohibit medication abortions, despite the fact that these are not "procedures" and therefore do not fall within the terms of the Executive Order at all.

15. Based on this enforcement risk, Southwestern cancelled 225 appointments scheduled for Tuesday, March 24 and Wednesday, March 25. Southwestern is unsure how to proceed but plans to resume certain appointments where care does not involve new PPE. Still, some patients who would have had medication abortions as scheduled prior to the Executive Order will require procedural abortions instead (and correspondingly greater amounts of PPE). And, some procedural patients may be pushed within days of the limit in Texas or beyond it.

16. If the Executive Order, as interpreted by the Attorney General, is enforced, it will deprive some patients of the freedom to make an intimate and personal decision essential to their dignity and autonomy. It will immeasurably harm patients' physical, emotional, and financial wellbeing and the wellbeing of their families.

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

Dr. Robin Wallace

Executed March 25, 2020

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE; *et al.*,	)	
	)	CIVIL ACTION
Plaintiffs,	)	
	)	CASE NO. 1:20-cv-323-LY
v.	)	
	)	
GREG ABBOTT, in his official capacity as Governor; *et al.*,	)	
	)	
Defendants.	)	

DECLARATION OF RASHAE WARD

RASHAE WARD, hereby declares under penalty of perjury that the following statements are true and correct:

1. I am the Hotline Coordinator of Lilith Fund, an Austin-based nonprofit organization that has been providing direct financial assistance to Texans who want to end a pregnancy, but cannot afford the cost of an abortion. Lilith Fund has served over 10,000 people since its founding nearly twenty years ago.

2. As Hotline Coordinator, I: 1) respond to requests from people struggling to arrange the costs of terminating a pregnancy; 2) recruit, train, supervise and support over 20 volunteers to do so; 3) decide how to allocate our limited budget to clients each day; 4) work with peer organizations and abortion providers throughout Texas, and more recently the country, to help ensure our clients can complete their appointments; 5) collaborate with our Program Manager to address systemic challenges in our clients' lives, including unemployment, housing insecurity, and intimate partner violence; and 6) partner with our Statewide Coordinator to help interested clients

educate their communities about the importance of meaningful abortion access. I have served in this position for almost a year.

3. I provide the following testimony based on personal knowledge acquired through my service at Lilith Fund and review of the organization's business records.

Barriers to Abortion Access in Texas Before the Executive Order

4. Our callers, most of whom are parents, lack insurance coverage for abortion care except in extremely narrow circumstances. Consequently, they must pay for their care of-out-pocket. Last year, Lilith Fund received nearly 6,600 calls, served over 1,617 individuals, and distributed over $489,515. The average cost of an abortion for our callers was $1,230. Unfortunately, we are able to help only about a quarter of all callers and even for the callers we can help, we can seldom cover the full cost of their care.

5. To assess their needs, we ask each caller their gestational age and discuss their socioeconomic circumstances in detail. If we are able to help the caller with the cost of care, Lilith Fund sends a financial voucher to the abortion provider with whom the caller has scheduled an appointment and pays the provider after the patient receives care.

6. Lilith Fund tries to prioritize callers who have reached later gestational ages, both because they risk exceeding the cut-off for a legal abortion in Texas—22 weeks, as measured from the first day of the last menstrual period ("lmp")), or for an abortion provided in an abortion clinic, as opposed to an ambulatory surgery center ("ASC"), in the State—18 weeks lmp. There are few ASCs in Texas, all of them in metropolitan areas, so many of the clients who exceed 18 weeks lmp must travel lengthy distances to obtain care, which in turn increases the funds they need to raise beforehand, including transportation and childcare costs. Another reason we try to prioritize callers

at later gestational ages is that the costs of abortion care rise as a pregnancy progresses. The average gestational age of our clients is 13 weeks lmp.

7. Lilith Fund also tries to prioritize callers who have decided that medication abortion is more appropriate for them than procedural abortion, but who risk exceeding Texas's gestational age cut-off for that care, 10 weeks lmp. Given when some of our callers discover they are pregnant, and the time it can take someone living in poverty to raise money for unexpected extended travel, the State's requirement that most abortion patients make two trips to obtain care makes it especially difficult not to pass this window.

8. Likewise, Lilith Fund tries to prioritize callers contending with multiple hardships, including homelessness, incarceration, intimate partner violence, and physical or mental health issues. To serve these clients, we typically coordinate with organizations that offer practical support for obtaining an abortion, including assistance with transportation, lodging, and meals. We have a practice of following up with clients soon after their scheduled appointment. In some cases, we learn that the client never made it to the abortion provider because, even with organizational assistance, they were unable to meet the total costs of obtaining an abortion in Texas.

9. Collaborating with our Program Manager to continue serving clients after they have obtained abortion care has helped me understand these barriers, how they exacerbate one another, and how Texas abortion restrictions compound them, even more deeply. Last year, we connected 64 clients with food banks and programs offering job assistance, help paying utility bills, and free diapers. Similarly, partnering with our Statewide Coordinator to connect clients to support groups and story-telling campaigns has shown me how our clients carry the strain and indignity of struggling to terminate a pregnancy in Texas with them long after they obtain care.

10. As with the rest of the country, the COVID-19 crisis has challenged our clients in unprecedented ways. Many work in the food services industry. So, in addition to coping with serious illness among their families and communities, they are losing their jobs, including their health insurance, and facing eviction. One client recently worked to raise money for her abortion care for weeks only to have to use it for rent. And some clients are effectively stuck in abusive situations. Since January 2020, callers have tended to be further along in their pregnancies due to the increasing difficulty of making travel arrangements, particularly for long-distance travel. The average gestational age has increased from 13 weeks lmp to 16 weeks lmp. Lilith Fund has increased the average amount of its vouchers from $207 to $267 to help meet these challenges. Nevertheless, I struggle with decisions of how to allocate funds among callers now more than ever. All too many people need them, there are never enough, and the stakes could not be higher.

Impact of Executive Order on Abortion Access During the Pandemic

11. After Attorney General Paxton threatened to enforce Governor Abbott's Executive Order (EO) as an abortion ban, thirteen of our clients' appointments were cancelled. Thankfully, four clients were able to terminate their pregnancies during the less-than-24-hour-period when the State was unable to enforce the EO due to a legal decision.

12. At least ten of our clients have lost or will lose the ability to obtain an abortion in Texas because they will have exceeded 22 weeks lmp as of the EO's expiration date. As of today, these clients are traveling out of state during a pandemic to secure medical services they could otherwise obtain in Texas, and in some cases, their own communities. They will be forced to travel to incredibly far destinations because they offer the earliest opportunity to obtain critical healthcare. In fact, the average distance traveled by our clients has jumped from 158 miles in 2019 to 734 miles since the EO.

13. One client, who the EO pushed to 19 weeks lmp, recently traveled over 300 miles from Houston to Atlanta, Georgia, an epicenter of the COVID-19 outbreak, because she would be at the precipice of 22 weeks lmp when the EO expires. Without the EO, she would have been able to terminate her pregnancy 3 weeks earlier within 3 miles of her home. Likewise, eight clients at 23, 22, 22, 19, 19, 19, 19, and 20 weeks lmp have secured abortion appointments in Albuquerque, New Mexico. Given the limited availability of abortion appointments at later gestational ages throughout the country, Lilith Fund is working to build relationships with another abortion provider in New Mexico and one in Illinois, where Texans affected by the EO will likely seek care in future weeks as they too near the gestational cut-off for legal abortion in Texas.

14. Most of our clients are flying rather than driving out of state because the health risks involved in air travel have made it much more affordable—and our clients lack the privilege to choose the more expensive, but likely safer option of driving.

15. These journeys, fraught in ordinary times, would be impossible without ongoing financial and practical support from nonprofit organizations. This includes funding for abortions at later gestational ages; since the EO, the average cost of an abortion for our clients has skyrocketed from $1,230 to $2,689, a 118% increase. Thus, we have further increased the average amount of our vouchers from $267 to $363. Support also includes the rapid arrangement of transportation and lodging, including the bravery of volunteers risking their health and safety to drive abortion patients to and from unfamiliar airports, and reimbursement for gasoline.

16. At least one client, who is at 19 weeks lmp, and whose abortion appointment was scheduled in Houston before the EO, worries about raising the funds and coordinating the travel needed to make a lengthy trip during the public health crisis, even with organizational assistance.

She also agonizes about the risk of contracting COVID-19, and of exposing her fetus to the virus, if the trip is unsuccessful and she is forced to carry to term.

17. Indeed, many clients are wrestling with acute fear and anxiety over whether they will be able to complete such trips, all the while contending with symptoms of pregnancy, such as severe morning sickness. And they are frustrated and angry that their Government, while urging other Texans to stay home, is driving them into hotbeds for the virus and putting them at greater risk of contracting and transmitting COVID-19 to their loved ones.

Dated: April 8, 2020

/S/ Rashae Ward
Rashae Ward
Hotline Coordinator
Lilith Fund

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD CENTER FOR CHOICE; *et al.*,	)	
Plaintiffs,	)	CASE NO. 1:20-cv-323-LY
v.	)	
GREG ABBOTT, in his official capacity as Governor; *et al.*,	)	
Defendants.	)	

DECLARATION OF RITA GOLIKERI WOOD, D.O., IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

RITA GOLIKERI WOOD, D.O., hereby declares under penalty of perjury that the following statements are true and correct:

1. I am an obstetrician-gynecologist ("OB/GYN") with a private practice in Fort Worth, Texas.

2. I obtained my medical degree from the Texas College of Osteopathic Medicine at University of North Texas Health Science Center.

3. I completed a residency in obstetrics and gynecology at John Peter Smith Hospital in Fort Worth.

4. I am a member of the American College of Obstetricians and Gynecologists ("ACOG") and the Texas Medical Association.

5. I provide the following testimony based on my personal knowledge as well as my training and experience as an OB/GYN.

6. In my office, I provide general gynecological care, family planning services, and obstetrics care. In January and February of this year, I treated 15 patients per day, on average.

7. I also provide labor and delivery services in a hospital setting. I currently have admitting privileges at two hospitals in Fort Worth. In January and February of this year, I delivered approximately 20 to 25 babies.

8. Since the COVID-19 outbreak, I have altered my practice in various ways to minimize the risk that my patients, my colleagues, or I will be exposed to the virus. For example, I have cancelled office visits for routine gynecological care and family planning services. I treat these patients via telemedicine when possible. My office screens patients for COVID-19 symptoms by phone in advance of their appointments and declines to see symptomatic patients, instead referring them for virus testing and treatment as consistent with current federal and state guidelines. We also take patients' temperatures at the door and similarly screen out those with fevers. We have tried to minimize the number of people in the office at a given time by asking patients not to bring companions and having them wait in their cars until I can see them.

9. Currently, I see fewer than ten patients per day in my office—primarily those who are pregnant or have urgent gynecological needs that cannot be addressed through telemedicine.

10. Some obstetrical care may be provided via telemedicine, but much of it requires in-person visits.

11. I currently recommend that patients with low-risk, uncomplicated pregnancies come in for an appointment once per month during the first trimester and early second-trimester. Beginning at 28 weeks of pregnancy, I recommend that they come in every two weeks. Patients with high-risk pregnancies or complications need to come in more often. I typically request a urine sample from patients during each visit. The samples are tested by a medical assistant in an on-site laboratory in my office.

12. Factors that make pregnancies high risk include being over 35 years old; obesity; underlying medical conditions such as high blood pressure, diabetes, epilepsy, etc.; and carrying twins or higher order multiples. Pregnancy-related complications include abnormal placentation; gestational diabetes; and pre-eclampsia, among others.

13. Approximately 30 percent of my obstetrical patients are high-risk or have complications.

14. In addition to regular office visits, obstetrical patients also require ultrasound examinations to determine whether the pregnancy is developing normally. For patients with low-risk, uncomplicated pregnancies, I currently recommend one ultrasound examination at the start of care to establish gestational age and viability of the pregnancy; one at 18-20 weeks of pregnancy; and one in the late second trimester or early third trimester. Patients with high-risk pregnancies or complications require more frequent ultrasounds.

15. My recommendations about the frequency of pre-natal visits and ultrasound examinations are based on guidelines from ACOG and the Society for Maternal-Fetal Medicine.

16. When treating pregnant patients in my office, I typically wear the following forms of personal protective equipment ("PPE"): non-sterile gloves, surgical masks, and scrubs. I may also wear sterile gloves if I need to perform a sterile vaginal examination. I change gloves between patients and may also change gloves several times during a single patient's appointment, depending on the circumstances. I also change my mask between patients. The medical assistant who processes urine samples wears non-sterile gloves and changes them periodically.

17. The ultrasound technician in my office typically wears non-sterile gloves for both transvaginal and transabdominal ultrasound examinations. I sometimes perform ultrasound examinations myself, and I also wear non-sterile gloves. The choice between transvaginal

ultrasound and transabdominal ultrasound varies based on several factors including the sensitivity of the ultrasound machine; the gestational age of the pregnancy; and the size and shape of the patient's body.

18. I am currently offering all pregnant patients the option of wearing a surgical mask in my office.

Dated: April 2, 2020

Rita Golikeri Wood

Rita Golikeri Wood, D.O.

No. 20-50296

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

In re GREG ABBOTT, in his official capacity as Governor of Texas; KEN PAXTON, in his official capacity as Attorney General of Texas; PHIL WILSON, in his official capacity as Acting Executive Commissioner of the Texas Health and Human Services Commission; STEPHEN BRINT CARLTON, in his official capacity as Executive Director of the Texas Medical Board; and KATHERINE A. THOMAS, in her official capacity as Executive Director of the Texas Board of Nursing.

On Petition for a Writ of Mandamus from the United States District Court,
Western District of Texas, Austin Division
No. 1:20-cv-00323-LY

RESPONDENTS' EMERGENCY MOTION TO LIFT PARTIAL ADMINISTRATIVE STAY

PATRICK J. O'CONNELL
Law Offices of Patrick J. O'Connell PLLC
5926 Balcones Dr., Ste. 220
Austin, Texas 78731
(512) 852-5918
pat@pjofca.com
Counsel for Plaintiffs-Respondents

[Additional counsel on inside cover]

JULIE A. MURRAY
HANNAH SWANSON
Planned Parenthood Federation of America
1110 Vermont Ave., NW, Ste. 300
Washington, DC 20005
(202) 973-4800

JENNIFER SANDMAN
Planned Parenthood Federation of America
123 William St., 9th Floor
New York, NY 10038
(212) 541-7800
Counsel for Plaintiffs-Respondents Planned Parenthood Center for Choice, Planned Parenthood of Greater Texas Surgical Health Services, and Planned Parenthood South Texas Surgical Center

Additional counsel:

STEPHANIE TOTI
RUPALI SHARMA
Lawyering Project
25 Broadway, 9th Floor
New York, NY 10004
(646) 490-1083
Counsel for Plaintiffs-Respondents Whole Woman's Health and Whole Woman's Health Alliance

MOLLY DUANE
Center for Reproductive Rights
199 Water St., 22nd Floor
New York, NY 10038
(917) 637-3631
Counsel for Plaintiffs-Respondents Southwestern Women's Surgery Center, Brookside Women's Medical Center PA d/b/a Brookside Women's Health Center and Austin Women's Health Center, and Robin Wallace, M.D.

CERTIFICATE OF INTERESTED PERSONS

No. 20-50296, *In re Greg Abbott, et al.*

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Fifth Circuit Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

Plaintiffs-Respondents	**Counsel**
1. Planned Parenthood Center for Choice 2. Planned Parenthood of Greater Texas Surgical Health Services 3. Planned Parenthood South Texas Surgical Center 4. Whole Woman's Health 5. Whole Woman's Health Alliance 6. Southwestern Women's Surgery Center 7. Brookside Women's Medical Center PA d/b/a Brookside Women's Health Center and Austin Women's Health Center 8. Robin Wallace, M.D.	1. Law Offices of Patrick J. O'Connell PLLC (Patrick J. O'Connell) 2. Planned Parenthood Federation of America (Jennifer Sandman, Julie Murray, Hannah Swanson) 3. Center for Reproductive Rights (Molly Duane, Rabia Muqaddam, Francesca Cocuzza) 4. Lawyering Project (Stephanie Toti, Rupali Sharma)
Defendants-Petitioners	**Counsel**
1. Greg Abbott, Governor of the State of Texas 2. Ken Paxton, Attorney General of Texas 3. Phil Wilson, Acting Executive Commissioner of the Texas Health and	1. Office of the Attorney General of Texas (Kyle D. Hawkins, Jeffrey C. Mateer, Andrew B. Stephens, Heather G. Hacker, Benjamin S. Walton, Beth Klusmann, Natalie D.

Human Services Commission 4. Stephen Brint Carlton, Executive Director of the Texas Medical Board 5. Katherine A. Thomas, Executive Director of the Texas Board of Nursing	Thompson)
Defendants	**Counsel**
1. Margaret Moore, District Attorney for Travis County 2. Joe Gonzales, Criminal District Attorney for Bexar County 3. John Creuzot, District Attorney for Dallas County 4. Jaime Esparza, District Attorney for El Paso County 5. Kim Ogg, Criminal District Attorney for Harris County 6. Ricardo Rodriguez, Jr., Criminal District Attorney for Hidalgo County 7. Barry Johnson, Criminal District Attorney for McLennan County 8. Sharen Wilson, Criminal District Attorney for Tarrant County 9. Brian Middleton, Criminal District Attorney for Fort Bend County	1. Office of the Dallas County District Attorney (John J. Butrus, Jr.) 2. Office of the Fort Bend County District Attorney (Justin C. Pfeiffer)
Amici Curiae	**Counsel**
1. Attorneys General of the States of Alabama, Alaska, Arkansas, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, and West Virginia 2. American Center for Law and Justice 3. American Association of Pro-Life Obstetricians and Gynecologists; Texas Values; Indiana Family	1. Louisiana Department of Justice (Jeff Landry, Elizabeth Murrill, J. Scott St. John) 2. Lill Firm, P.C. (David S. Lill) 3. American Center for Law and Justice (Jay A. Sekulow, Edward L. White III, Jordan Sekulow, Stuart J. Roth, Erik M. Zimmerman, Benjamin P. Sisney, Olivia F. Summers, Christina A. Stierhoff)

Institute; Family Heritage Alliance Action, South Dakota; Minnesota Family Council; Wisconsin Family Action; Alaska Family Action; California Family Council; Ohio Citizens for Community Values; Nebraska Family Alliance; Family Policy Institute of Washington; The Family Foundation (Kentucky); Louisiana Family Forum 4. American College of Obstetricians and Gynecologists; American Medical Association; American Academy of Family Physicians; American Academy of Nursing; American Academy of Pediatrics; AAGL; American College of Nurse-Midwives; American College of Osteopathic Obstetricians and Gynecologists; American College of Physicians; American Osteopathic Association; American Psychiatric Association; American Society of Reproductive Medicine; American Urogynecologic Society; North American Society for Pediatric and Adolescent Gynecology; National Association of Nurse Practitioners in Women's Health; Society of Family Planning; Society for Maternal-Fetal Medicine; Society of Gynecologic Oncology; Society of Gynecologic Surgeons; Society of OB/GYN Hospitalists 5. Attorneys General of the States of New York, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Mexico, Oregon, Pennsylvania, Rhode Island,	4. Mitchell Law PLLC (Jonathan F. Mitchell) 5. Texas Values (Jonathan M. Saenz) 6. Mayer Brown (Nicole A. Saharsky, Kathleen S. Messinger) 7. American College of Obstetricians and Gynecologists (Skye L. Perryman) 8. Office of the New York State Attorney General (Letitia James, Barbara D. Underwood, Anisha S. Dasgupta, Laura Etlinger)

Vermont, Virginia, Washington, and the District of Columbia	

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INTRODUCTION

On April 10, 2020, Defendants-Petitioners ("State Officials") filed an emergency motion for an administrative stay of the district court's limited temporary restraining order ("Limited TRO"), which partially enjoined enforcement of a Texas executive order that State Officials interpret to prohibit nearly all abortions during the COVID-19 pandemic. Without awaiting an opposition from Plaintiffs-Respondents ("Providers"), this Court granted the motion in part and entered an administrative stay with no formal expiration date of key portions of the Limited TRO.

Providers file this emergency motion to lift the administrative stay. On remand, responding directly to this Court's guidance, the district court issued a narrow TRO tailored to the record before it (which contains evidence not before the district court at the time of its prior TRO). This Limited TRO temporarily blocks enforcement of Texas Governor Greg Abbott's March 22, 2020, Executive Order GA-09 ("Executive Order") only as to (1) medication abortion and (2) abortion for patients who would otherwise be prevented from accessing that care before expiration of the Executive Order, as described more specifically in the Limited TRO. Immediate dissolution of the administrative stay is necessary to prevent severe and lasting harm to Providers' patients and public health.

Respondents have conferred with Petitioners, who indicate that they oppose this motion.

ARGUMENT

The administrative stay is at odds with the district court's express finding that the Limited TRO is *necessary* to prevent irreparable harm to Providers' patients who have been unable to obtain abortions since the Executive Order went into effect on March 22, 2020. Providers have already turned away hundreds of patients seeking abortion care, including during a previous week-long administrative stay entered by this Court to resolve State Officials' first petition for a writ of mandamus. They will turn away hundreds more in the coming days if this Court does not lift its latest administrative stay. App.473–74.

Those patients will include individuals likely or certain to lose their right to obtain an abortion in the State of Texas by the time the Executive Order expires, even assuming the order is not extended, because the patients' pregnancies will exceed eighteen weeks LMP by April 22, 2020, and, in the judgment of their medical providers, they will likely be unable to access care at one of the few ambulatory surgical centers ("ASCs") in Texas.[1] Those patients will also include those seeking

[1] Tex. Health & Safety Code § 171.044. This statute bans most abortion after twenty weeks post-fertilization. Fertilization generally occurs about two weeks after the first day of the pregnant patient's last menstrual period ("LMP"), so twenty weeks post-fertilization equates to roughly twenty-two weeks LMP.

a medication abortion, which is not a "procedure" under the Executive Order and, as the district court found, does not require the use of PPE.

There is no basis for State Officials' claim that mandamus is appropriate here. As Providers would describe in an opposition to that petition, the district court correctly applied this Court's previous mandamus order. Under that decision, certain applications of the Executive Order may amount to an undue burden under *Planned Parenthood Southeast Pennsylvania v. Casey* where, "'beyond question,' the Executive Order's burdens outweigh its benefits in those situations." *In re Greg Abbott*, No. 20-50264, 2020 WL 1685929, at *9 (5th Cir. Apr. 7, 2020) (quoting *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11 (1905)). This Court's mandamus order expressly recognized that the Executive Order contains an exception for procedures that "if performed under normal clinical standards 'would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster,'" and stated that the district court's prior, broad TRO contained no findings about the use of PPE in medication abortion. *Id*. at *9, *11. It also recognized that relief may be appropriate for patients whose pregnancies will reach or exceed a point after which abortion services would be unavailable in Texas. *Id*. at *11. The district court correctly concluded that Providers are likely to meet the standard set forth in this Court's mandamus order as to abortion in the limited circumstances at issue here.

First, the record demonstrates that medication abortion is not a "procedure" and requires no PPE, App.73, 86, 91, 100, 110, 117, 129–30, 134, 157, 469–70, so it does not cause any of the problems addressed by the Executive Order, which on its face applies only to "surgeries and procedures." App.35; *see also* Tex. Med. Bd., Updated Texas Medical Board (TMB) Frequently Asked Questions (FAQs) Regarding Non-Urgent, Elective Surgeries and Procedures During Texas Disaster Declaration for COVID-19 Pandemic (Mar. 29, 2020).[2] The record further shows that complications from medication abortion are exceedingly rare, and follow-up aspiration procedures, where necessary, can almost always be performed in an outpatient setting. App.129, 373, 470. The district court also found that the ultrasounds and ancillary services attendant to medication abortion are not "procedures" governed by the Executive Order based on Defendant Texas Medical Board's own guidance document, and that, in any event, the PPE used at this stage of pregnancy is greater for individuals who remain pregnant than for those who have an abortion. App.470, 472–73. In addition, it found that Texas obstetricians are continuing to provide in-person visits to pregnant patients, including ultrasounds and other ancillary services. App.472.

[2] *Available at* http://www.tmb.state.tx.us/idl/59C97062-84FA-BB86-91BF-F9221E4DEF17.

As to the burdens of the Executive Order as applied to medication abortion, the district court found, based on the evidentiary record, that the health risks associated with both pregnancy and abortion increase with gestational age. App.474. The district court likewise found, based on the record, that people with ongoing pregnancies must cope with the physical symptoms of pregnancy; must struggle to conceal their pregnancies from abusive partners or family members; and must deal with the stress and anxiety of not knowing when—or if—they will be able to obtain an abortion. App.475. The district court also found that the Executive Order is causing individuals who have the ability to travel to go to other states to obtain abortions. The record shows that these individuals, including individuals seeking medication abortion, are traveling by both car and airplane to places as far away as Colorado and Georgia, at odds with the recommendations of public health officials. App.473.

The district court was correct that the burdens the Executive Order imposes on these individuals, *beyond all doubt*, outweigh any benefits that the Executive Order may confer. *See S. Wind Women's Ctr. LLC v. Stitt*, No. CIV-20-277-G, 2020 WL 1677094, at *2, 5 (W.D. Okla. Apr. 6, 2020) (quoting *Jacobson*, 197 U.S. at 31) ("[T]he benefit to public health of the ban on medication abortions is minor and outweighed by the intrusion on Fourteenth Amendment rights caused by that ban."). There is no error in the district court's conclusion in this regard.

Second, the Executive Order undeniably operates as an undue burden as to people whose pregnancies will, by expiration of the Executive Order, reach eighteen weeks LMP and who, in the judgment of their physician, would not be able to access abortion care at one of the State's few ASCs. At that point, outpatient procedural abortions may only be performed at ASCs,[3] but there are no ASCs that provide abortion care outside of Texas's four largest metropolitan areas. *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2316 (2016). Accordingly, patients who are unable to obtain care at an ASC after eighteen weeks LMP will be denied an abortion entirely. Because the Executive Order as applied to abortion in those circumstances would have the effect of foreclosing the right to abortion altogether, *see id*. at 2316–18, it "constitute[s] an undue burden under *Casey*" and is, "*beyond question*, in palpable conflict with the Constitution," *In re Greg Abbott*, 2020 WL 1685929, at *10.

The district court's Limited TRO grants relief in these limited circumstances only, and for a limited time: it expires in just over a week, on April 19, 2020. As the district court expressly found, again in response to this Court's previous decision, the Executive Order as applied to this limited subset of patients does not serve public health. Indeed, based on the declarations of Texas obstetrician-gynecologists and national public-health experts, the district court found that entry of the Limited TRO

[3] Tex. Health & Safety Code § 171.004.

to restore some abortion access would *serve* Texas's interest in public health. App.477. This is because patients denied access to medication abortion and procedural abortion later in pregnancy will consume more PPE and hospital resources by remaining pregnant than if they receive abortions.[4]

Finally, Providers request that this Court lift the administrative stay because the stay's result—permitting Texas officials to impose the most extreme abortion restriction in the country—is at odds with the decisions of every district court to consider these issues and enter relief. Those other courts have enjoined application of "essential surgery" executive orders to abortion in circumstances similar to those at issue in this case,[5] and a sister circuit has concluded that such relief would not "inflict irretrievable harms or consequences before the TRO expires." *Preterm-Cleveland v. Att'y. Gen. of Ohio*, No. 20-3365, 2020 WL 1673310, at *1–2 (6th Cir.

[4] Indeed, in enforcing a similar executive order, Ohio recognized the public health need to allow medication abortions and abortions for patients close to a gestational-age cutoff. *See* Defendants Ohio Dep't of Health, State Med. Bd. of Ohio, and Ohio Att'y Gen. Dave Yost's Response to Plantiffs' Motion for Preliminary Injunction at 27, *Preterm-Cleveland v. Att'y Gen. of Ohio*, No. 1:19-cv-00360 (S.D. Ohio Apr. 8, 2020), ECF No. 59 ("Doctors should perform medicinal abortions (rather than surgical abortions) where that option is safe and available. Doctors remain free to perform surgical abortions necessary for a mother's health or life, and also surgical abortions that cannot be delayed without jeopardizing the patient's abortion rights.")

[5] *See generally Preterm-Cleveland v. Att'y. Gen. of Ohio*, No. 1:19-cv-00360-MRB, slip op. (S.D. Ohio Mar. 30, 2020); *Robinson v. Marshall*, No. 2:19cv365-MHT, 2020 WL 1659700 (M.D. Ala. Apr. 3, 2020); *S. Wind Women's Center LLC v. Stitt*, 2020 WL 1677094.

Apr. 6, 2020). Meanwhile, the administrative stay is already causing irreparable harm to the health and rights of hundreds of Texans, and will exacerbate the spread of COVID-19 by forcing people to travel out of state for care that the TRO would allow them to obtain safely closer to home.

CONCLUSION

For the foregoing reasons, this Court should lift the administrative stay without delay. Given the nature of the harms imposed by the stay, Respondents request a decision on their emergency motion by April 10, 2020.

Dated: April 10, 2020

Respectfully submitted,

/s/ Patrick J. O'Connell
PATRICK J. O'CONNELL
Law Offices of Patrick J. O'Connell PLLC
5926 Balcones Dr., Ste. 220
Austin, Texas 78731
(512) 852-5918
pat@pjofca.com
Counsel for Plaintiffs-Respondents

STEPHANIE TOTI
RUPALI SHARMA
Lawyering Project
25 Broadway, 9th Floor
New York, NY 10004
(646) 490-1083

/s/ Julie A. Murray
JULIE A. MURRAY
HANNAH SWANSON
Planned Parenthood Federation of America, Inc.
1110 Vermont Ave., NW, Ste. 300
Washington, DC 20005
(202) 973-4800
julie.murray@ppfa.org
hannah.swanson@ppfa.org

JENNIFER SANDMAN
Planned Parenthood Federation of America, Inc.
123 William St., 9th Floor
New York, NY 10038

stoti@lawyeringproject.org
rsharma@lawyeringproject.org
Counsel for Plaintiffs-Respondents Whole Woman's Health and Whole Woman's Health Alliance

MOLLY DUANE
Center for Reproductive Rights
199 Water St., 22nd Floor
New York, NY 10038
(917) 637-3631
mduane@reprorights.org
Counsel for Plaintiffs-Respondents Southwestern Women's Surgery Center, Brookside Women's Medical Center PA d/b/a Brookside Women's Health Center and Austin Women's Health Center, and Robin Wallace, M.D

(212) 541-7800
jennifer.sandman@ppfa.org
Counsel for Plaintiffs-Respondents Planned Parenthood Center for Choice, Planned Parenthood of Greater Texas Surgical Health Services, and Planned Parenthood South Texas Surgical Center

CERTIFICATE OF SERVICE

I hereby certify that on April 10, 2020, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit by using the CM/ECF system. I certify that counsel for the Defendants-Petitioners are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

/s/ *Julie Murray*
Julie Murray

CERTIFICATION OF COMPLIANCE WITH RULE 27.3

In compliance with Fifth Circuit Rule 27.3, I certify the following:

- Before filing this motion, counsel for Respondents contacted the clerk's office and opposing counsel to advise them of Respondents' intent to file this motion.
- The facts stated herein supporting emergency consideration of this motion are true and complete.
- The Court's review of this motion is requested as soon as possible, but no later than 9 p.m. Central Time, Friday, April 10, 2020.
- True and correct copies of relevant orders and other documents are included in the Appendix to Petitioners' petition for writ of mandamus.
- This motion is being served at the same time it is being filed.

/s/ *Julie Murray*
Julie Murray

CERTIFICATE OF COMPLIANCE WITH TYPE-FACE AND VOLUME LIMITATIONS

Pursuant to Fed. R. App. P. 32(g), I hereby certify that the foregoing complies with the type-volume limitation of Fed. R. App. P. 27(d)(2)(A) because it contains 1,759 words, excluding the items exempted by Fed. R. App. P. 32(f). This document complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) because this document has been prepared in a proportionally spaced typeface using Microsoft Word in 14-point Times New Roman font.

Dated: April 10, 2020

/s/ *Julie Murray*
Julie Murray

United States Court of Appeals

FIFTH CIRCUIT
OFFICE OF THE CLERK

LYLE W. CAYCE
CLERK

TEL. 504-310-7700
600 S. MAESTRI PLACE,
Suite 115
NEW ORLEANS, LA 70130

April 10, 2020

Ms. Heather Gebelin Hacker
Office of the Attorney General
for the State of Texas
209 W. 14th Street
Price Daniels Sr. Building
Austin, TX 78701-1614

Mr. Kyle Douglas Hawkins
Office of the Attorney General
Office of the Solicitor General
P.O. Box 12548 (MC 059)
Austin, TX 78711-2548

Ms. Beth Ellen Klusmann
Office of the Attorney General
Office of the Solicitor General
P.O. Box 12548 (MC 059)
Austin, TX 78711-2548

Mrs. Natalie Deyo Thompson
Office of the Attorney General
Office of the Solicitor General
P.O. Box 12548 (MC 059)
Austin, TX 78711-2548

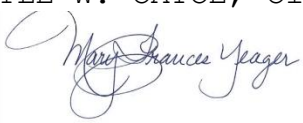
No. 20-50296 In re: Greg Abbott, et al
USDC No. 1:20-CV-323

Dear Counsel:

This letter will serve to advise the parties that the court has requested a response to the Respondents' Motion to lift stay be filed in this office on or before 5:00pm, April 11, 2020.

Sincerely,

LYLE W. CAYCE, Clerk



By: _____
Mary Frances Yeager, Deputy Clerk
504-310-7686

cc: Mrs. Molly Rose Duane
Mr. Richard Muniz
Ms. Julie A. Murray
Mr. Patrick J. O'Connell
Ms. Jennifer Sandman
Ms. Rupali Sharma
Ms. Hannah Swanson
Ms. Stephanie Toti

CERTIFICATE OF SERVICE

I, Julie A. Murray, a member of the bar of this Court, certify that on this 11th day of April, 2020, I caused all parties requiring service in this matter to be served with a copy of the foregoing by email and first class mail to the individuals listed below:

KYLE D. HAWKINS, SOLICITOR GENERAL
HEATHER GEBELIN HACKER
BETH KLUSMANN
Office of the Attorney General
P.O. Box 12548 (MC 059)
Austin, Texas 78711-2548
Tel.: (512) 936-1700
Fax: (512) 474-2697
Kyle.Hawkins@oag.texas.gov
Heather.Hacker@oag.texas.gov
Beth.Klusmann@oag.texas.gov

/s/ Julie A. Murray
JULIE A. MURRAY
Counsel of Record