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CLERK OF THE SHAWNEE COUNTY DISTRICT COURT
CASE NUMBER: 2019-CV-000060

IN THE THIRD JUDICIAL DISTRICT
DISTRICT COURT, SHAWNEE COUNTY, KANSAS
DIVISION 3

TRUST WOMEN FOUNDATION INC. d/b/a SOUTH WIND WOMEN'S CENTER d/b/a TRUST WOMEN WICHITA,	)	
Plaintiff,	)	
v.	)	Case No. 2019 CV 60
MARC BENNETT, in his official capacity as District Attorney for Sedgwick County, Kansas; KATHLEEN SELZER LIPPERT, in her official capacity as the Executive Director of the Kansas Board of Healing Arts; and ROBIN D. DURRETT, in her official capacity as President of the Kansas Board of Healing Arts; DEREK SCHMIDT, in his official capacity as Attorney General of the State of Kansas,	)	
Defendants.	)	

MOTION FOR TEMPORARY INJUNCTION AND TEMPORARY RESTRAINING ORDER

Come now Plaintiff and pursuant to K.S.A. § 60-903 and § 60-905 hereby applies to this honorable Court for the issuance of a Temporary Injunction and a Temporary Restraining Order enjoining Defendants, their agents, and their successors in office from enforcing K.S.A. § 65-4a10 (the "medication in-person requirement") and Sections 6 and 7 of Kansas House Bill 2028, K.S.A §§40-2,210-40-2,216 ("the Act"). When read in conjunction with the medication in-person requirement, Section 6 of the Act will prohibit the delivery of any abortion procedure via telemedicine. Together the medication in-person requirement and Sections 6 and 7 of the Act are referred to as the "Challenged Laws." In support of this motion, Plaintiff submits a memorandum

of law and the affidavits of Daniel Grossman, M.D. (Exhibit 1), Julie Burkhart (Exhibit 2), Colleen McNicholas M.D., D.O., M.S.C.I., F.A.C.O.G. (Exhibit 3), and a copy of the Agreed Order from *Hodes & Nauser v. Moser*, No. 11 C 1298 (Dec. 2, 2011, Shawnee County Dist. Ct.) (Exhibit 4).

As set out in the accompanying memorandum of law, Plaintiff has demonstrated a reasonable probability that it and its patients would suffer irreparable injuries, for which there is no adequate remedy at law, if the Challenged Laws are not enjoined. The Challenged Laws would impose health risks on Plaintiff's patients and would violate rights afforded to both Plaintiff and its patients by the Kansas Constitution. Plaintiff's application is supported by specific facts that clearly show its entitlement to a temporary injunction, which will prevent injury to and maintain the *status quo* pending final resolution of the significant constitutional claims at issue.

Pending the Court's ruling on the motion, Plaintiff seeks, in the alternative, a Temporary Restraining Order to remain in effect until the Motion for Temporary Injunction is decided.

Because Defendants stand to suffer no pecuniary harm as a result of the requested injunctive relief, Plaintiff asks that if a Temporary Injunction or Temporary Restraining Order is issued, the Court exercise its discretion under K.S.A. § 60-905(b), to enter the Order without requiring the Plaintiff to post a bond.

Plaintiff will serve this motion and supporting papers on Defendants without delay. In addition, Plaintiff intends to provide copies of all of the documents via email.

WHEREFORE, Plaintiff asks the Court to grant it the following relief:

a. a temporary injunction, without bond, that restrains Defendants, their agents, and their successors in office from enforcing K.S.A. § 65-4a10 and Sections 6 and 7 of H.B. 2028 until the Court enters a final judgment in this case; and

b. if necessary, a temporary restraining order, without bond, that restrains Defendants, their agents, and their successors in office from enforcing K.S.A. § 65-4a10 and

Sections 6 and 7 of H.B. 2028 until the Court issues a ruling on Plaintiff's request for a temporary injunction; and

c. such other and further relief as the Court deems just, proper, and equitable.

Respectfully submitted, this 4th day of March, 2019.

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COUNSEL FOR PLAINTIFF

Exhibit 1

IN THE THIRD JUDICIAL DISTRICT
DISTRICT COURT, SHAWNEE COUNTY, KANSAS
DIVISION 3

TRUST WOMEN FOUNDATION INC. d/b/a SOUTH WIND WOMEN'S CENTER d/b/a TRUST WOMEN WICHITA, Plaintiff, v. MARC BENNETT, in his official capacity as District Attorney for Sedgwick County, Kansas; KATHLEEN SELZER LIPPERT, in her official capacity as the Executive Director of the Kansas Board of Healing Arts; and ROBIN D. DURRETT, in her official capacity as President of the Kansas Board of Healing Arts; and DEREK SCHMIDT, in his official capacity as Attorney General of the State of Kansas, Defendants.	)	Case No. 2019-CV-60

AFFIDAVIT OF DANIEL A. GROSSMAN, M.D. IN SUPPORT OF MOTION FOR TEMPORARY INJUNCTION AND TEMPORARY RESTRAINING ORDER

DANIEL A. GROSSMAN, M.D., of lawful age and being duly sworn, declares as follows:

1. I am a Professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco (UCSF) and an obstetrician-gynecologist with over 20 years of clinical experience. I currently provide clinical services, including abortion services, at Zuckerberg San Francisco General Hospital. I am also a Fellow of the American College of Obstetricians and Gynecologists (ACOG), where I previously served as Vice Chair for

the Committee on Practice Bulletins for Gynecology. I am currently Chair of the Committee on Health Care for Underserved Women. I am also a Fellow of the Society of Family Planning and a member of the American Public Health Association (APHA). Additionally, I serve as Director of Advancing New Standards in Reproductive Health (ANSIRH) at UCSF. ANSIRH conducts innovative, rigorous, multidisciplinary research on complex issues related to people's sexual and reproductive lives. I am also Senior Advisor at Ibis Reproductive Health, a nonprofit research organization. I am a liaison member of the Planned Parenthood National Medical Committee, and between 2012 and 2015 I provided clinical services with Planned Parenthood Northern California (formerly Planned Parenthood Shasta Pacific). My research has been supported by grants from federal agencies and private foundations. I have published over 150 articles in peer-reviewed journals, and I am a member of the Editorial Board of the journal Contraception.

2. I have served as an expert in cases challenging medically unnecessary and targeted regulations of abortion providers, including in a case that was decided by the Iowa Supreme Court, *Planned Parenthood of the Heartland, Inc. v. Iowa Board of Medicine*, 865 N.W. 2d 252 (Iowa 2015). In that case, I testified that the Board of Medicine's restrictions on the use of telemedicine for medication abortion were medically unjustified and detrimental to women's health, and the Iowa Supreme Court ultimately struck down the rules as unconstitutional.

3. I earned a B.S. in Molecular Biophysics and Biochemistry from Yale University and an M.D. from Stanford University of Medicine. I completed a residency in Obstetrics, Gynecology, and Reproductive Sciences at UCSF.

4. A current version of my curriculum vitae (CV), which sets forth my experience and credentials more fully, is attached to this declaration. My CV contains a complete list of the publications that I have authored or co-authored.

5. I submit this affidavit in support of continuing the injunction against K.S.A. § 65-4a10 (the "medication in-person requirement") and enjoining enforcement of Section 6 of H.B. 2028 ("the Telemedicine Act") (together "the Challenged Laws"). I have reviewed both the medication in-person requirement and H.B. 2028 and I understand that the Challenged Laws prohibit the delivery of any abortion procedure via telemedicine. In my opinion, the use of telemedicine for medication abortion is as safe and effective as in-person treatment, and this prohibition will not benefit women's health but rather, will negatively affect women's health by delaying or preventing women from obtaining an abortion.

6. The opinions in this affidavit are based on my education, clinical training, experience as a practicing physician over the past twenty-four years, my medical research, regular review of other medical research in my field, and attendance at professional conferences. The facts in this declaration are based on my personal knowledge.

Access to Safe and Legal Abortion is Vital to Public Health

7. Women seek abortions for a variety of medical, familial, economic, and personal reasons. Fifty-nine percent of women who seek abortions are already mothers who have decided that they cannot parent another child at this time.[1] Approximately one out of four women in the United States will have an abortion in their lifetime.[2]

[1] Jenna Jerman, Rachel K. Jones, and Tsuyoshi Onda, Guttmacher Inst., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* (May 2016) [hereinafter *Characteristics of U.S. Abortion Patients*] https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014 (last visited Nov. 1, 2018).
[2] Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107(12) Am. J. Pub. Health 1904 (Dec. 2017); *see also Abortion Is a Common Experience for U.S. Women, Despite Dramatic Declines in Rates*, Guttmacher Inst. (Oct. 19, 2017), https://www.guttmacher.org/news-release/2017/abortion-common-experience-us-women-despite-dramatic-declines-rates (last visited Oct. 16, 2018).

8. It is extremely vital for women to have timely access to legal abortion. Women with unwanted pregnancies face increased risks of poor health outcomes when they do not have access to safe abortion.

9. Abortion is an extremely safe and common medical procedure in the United States. A recent analysis of abortion care in the United States performed by the National Academies of Sciences, Engineering, and Medicine, concluded that abortion is extremely safe, involving minimal risks.[3] However, the risks from abortion increase when the pregnancy is further along. Thus, delaying abortions and imposing significant obstacles on women seeking abortion care raises the risk of complications.[4] Additionally, later abortion is more expensive, is offered at fewer locations, and there are fewer providers.[5]

10. Some women turn to illegal and unsafe methods to terminate unwanted pregnancies when legal abortion is unavailable or difficult to access.[6] Other women that are deprived of access to legal abortion carry unwanted pregnancies to term. These women are exposed to increased risks of death and major complications from childbirth.[7] In addition, women who carry an unwanted pregnancy are less likely to obtain prenatal care and have lower breastfeeding

[3] National Academies of Sciences, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States*, at 77 (2018) [hereinafter NAS, *Safety and Quality of Abortion Care*], http://nap.edu/24950 ("The clinical evidence makes clear that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective.").
[4] Suzanne Zane et al., *Abortion-Related Mortality in the United States: 1998-2010*, 126(2) Obstetrics & Gynecology 258 (Aug. 2015); *see also* Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103(4) Obstetrics & Gynecology 729, 735 (Apr. 2004) [hereinafter *Risk Factors for Legal Induced Abortion*].
[5] Rachel K. Jones, Meghan Ingerick, & Jenna Jerman, *Difference in Abortion Service Delivery in Hostile, Middle-ground, and Supportive States in 2014*, 28(3) Women's Health Issues 212 (May-June 2018).
[6] Daniel Grossman et al., *Self-Induction of Abortion Among Women in the United States*, 18(36) Reprod. Health Matters 136 (Nov. 2010); Daniel Grossman et al., *The Public Health Threat of Anti-Abortion Legislation*, 89(2) Contraception 73, 73 (Feb. 2014); Tex. Policy Evaluation Project, *Research Brief: Texas Women's Experiences Attempting Self-Induced Abortion in the Face of Dwindling Option*s (Nov. 17, 2015), http://liberalarts.utexas.edu/txpep/_files/pdf/TxPEP-Research-Brief-WomensExperiences.pdf.
[7] Elizabeth G. Raymond and David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2) Obstetrics & Gynecology 215, 216 (Feb. 2012) [hereinafter *Comparative Safety of Legal Induced Abortion and Childbirth*].

rates, and women and their newborns are at risk of poor maternal and neonatal health outcomes.[8] Also, women forced to carry an unwanted pregnancy to term due to the lack of access find it harder to bring themselves and their family out of poverty.[9] In many cases, women who are victims of partner violence will experience great difficulty escaping that abusive relationship because of the financial, emotional, and legal ties to that partner.[10]

11. Women seeking an abortion also face significant personal, social, and financial obstacles. Most abortion patients live on incomes below 200% of the federal poverty level. [11] For these women in particular, it is a struggle to pull together the resources to take time off from work and arrange transportation to obtain an abortion. One study from Arizona, before that state's mandatory delay law went into effect, found that "the majority of women seeking abortion care had to forego or delay food, rent, childcare, or another important cost to finance their abortion."[12]

12. I understand that the majority of women seeking an abortion in Kansas are already parents, and many have multiple children. Therefore, they need to organize and/or pay for additional childcare when they have health care visits. These women may have inflexible work

[8] AP Mohllajee et al., *Pregnancy Intention and Its Relationship to Birth and Maternal Outcomes*, 109(3) Obstetrics & Gynecology 678 (Mar. 2007); Jessica D. Gipson, Michael A. Koenig, & Michelle J. Hindin, *The Effects of Unintended Pregnancy on Infant, Child and Parental Health: A Review of Literature*, 39(1) Study Fam. Plan. 18 (Feb. 2008).

[9] Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108(3) Am. J. Pub. Health 407 (Mar. 2018); Ushma D. Upadhyay, M. Antonia Biggs and Diana Greene Foster, *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15 BMC Women's Health 102 (Nov. 2015); Diana Greene Foster, Sarah E. Raifman, Jessica D. Gipson, Corinne H. Rocca, & M. Antonia Biggs, *Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children*, 205 J Pediatr 183-9 (Feb. 2019); Diana Greene Foster, M. Antonia Biggs, Sarah Raifman, Jessica Gipson, Katrina Kimport, & Corinne H. Rocca, *Comparison of Health, Development, Maternal Bonding, and Poverty Among Children Boran After Denial of Abortion vs After Pregnancies Subsequent to an Abortion*, 172(11) JAMA Pediatr 1053-1060 (Nov. 2018).

[10] Sarah C.M. Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 BMC Medicine 144 (Sep. 2014).

[11] *Characteristics of U.S. Abortion Patients* at 11 ("75% of abortion patients are low income, having family incomes of less than 200% of the federal poverty level.").

[12] Deborah Karasek, Sarah C.M. Roberts and Tracy A. Weitz, *Abortion Patients' Experience and Perception of Waiting Periods: Survey Evidence Before Arizona's Two-Visit 24-Hour Mandatory Waiting Period Law*, 26(1) Women's Health Issues 60, 64 (Jan.-Feb. 2016) [hereinafter *Abortion Patients' Experience and Perception of Waiting Periods*].

schedules and must work within narrow time constraints when arranging health care appointments. Some women must conceal these arrangements from abusive or controlling partners or family members.[13]

13. When analyzing the impact of a new abortion restriction, it is important to keep in mind the existing logistical, financial, stigmatic, and other burdens that women already face in seeking to access abortion care.

Abortion Methods in the United States

14. In the United States, there are generally two methods of performing an abortion: medical, by administering certain drugs, or surgical, using various methods depending on the gestational age of the fetus. This former method, which is known as a "medical" or "medication" abortion and which I refer to here as "medication abortion," is generally only available through 70 days after the first day of the woman's last menstrual period (LMP) or through ten weeks of pregnancy.

15. Medication abortion involves safely and effectively terminating a pregnancy non-surgically, through a combination of two prescription drugs: mifepristone and misoprostol. Mifepristone works by blocking the hormone progesterone, which is necessary to maintain pregnancy. Misoprostol then causes the cervix to open and the uterus to contract and expel its contents, generally within hours, thereby completing the abortion. Medication abortion requires

[13] *See* ACOG, *ACOG Comm. Op. No. 554: Reproductive & Sexual Coercion*, 121(2) Obstetrics & Gynecology 411 (Feb. 2013); Jenna Jerman, Rachel K. Jones, & Tsuyoshi Onda, Guttmacher Inst., *Characteristics of U.S. Abortion Patients in 2014 and Changes since 2008* at 7 (May 2016), https://www.guttmacher.org/sites/default/files/report_pdf/us-abortion-patients.pdf (59% of abortion patients surveyed already had children and one-third had two or more); Michael Lupfer and Bohne Goldfarb Silber, *How Patients View Mandatory Waiting Periods for Abortion*, 13(2) Fam. Plan. Persps. 75, 76-77 (Mar.-Apr. 1981) (describing problems with delay, including increased expenses and missing additional time at work); *Abortion Patients' Experience and Perception of Waiting Periods* at 62-63 (31 % reported compromised confidentiality because they had to tell someone they did not want to tell); Sarah E. Baum et al., *Women's Experience Obtaining Abortion Care in Texas After Implementation of Restrictive Abortion Laws: A Qualitative Study*, 11(10) PLoS One (Oct. 2016), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0165048.

no anesthesia or sedation; women are screened for eligibility and contraindications, receive counseling, and are then provided with the medication.

16. Surgical abortion involves the use of instruments to evacuate the contents of the uterus. Whereas first-trimester surgical abortion is generally a simple procedure lasting five to ten minutes, the method becomes longer and more complex later in pregnancy. Unlike medication abortion, surgical abortion often involves sedation and, in rare cases, involves general anesthesia.

17. Many women prefer medication abortion because they can complete the process in the privacy of their homes, with the company of loved ones, and at a time of their choosing. Studies in the United States and elsewhere have found that women are very satisfied with the medication abortion method, and many prefer it to vacuum aspiration.[14] [15]

18. Some women choose medication abortion because they fear a procedure involving surgical instruments. Victims of rape, or women who have experienced sexual abuse or molestation, may choose medication abortion to feel more in control of the experience and to avoid trauma from having instruments placed in their vagina.

19. For other women, there are medical reasons why medication abortion is better for them than surgical abortion. Some women have medical conditions that make medication abortion a significantly safer option, as it has a lower risk of both complications and failure than surgical abortion. These conditions include anomalies of the reproductive and genital tract, such as large uterine fibroids, female genital mutilation, vaginismus, or cervical stenosis, as well as severe

[14] Daniel Grossman et al., *Changes in Service Delivery Patterns After Introducing Telemedicine Provision of Medical Abortion in Iowa*, 103(1) Am. J. Pub. Health 73 (Jan. 2013) [hereinafter *Changes in Service Delivery Patterns After Introducing Telemedicine*].

[15] Vacuum aspiration, also known as suction curettage, is the method used for first-trimester abortions, where the uterine contents are removed by suction.

obesity or an extremely flexed uterus, all of which make it difficult to access the pregnancy inside the uterus as part of a surgical abortion.

20. For all of these reasons, it is critical to public health that women seeking an abortion can access care as early in their pregnancy as possible, when it is safest and, for those who prefer medication abortion, when they have the option of avoiding surgery.

Telemedicine Is Safe and Effective and Improves Access for Women Seeking Abortion

21. Telemedicine is the delivery of health care services at a distance through information and communication technology.[16] Telemedicine has been used to expand the reach of physicians in many disciplines around the country and found to be safe and effective.[17] Telemedicine for abortion services has the potential to provide abortion services earlier in pregnancy and closer to a woman's home and to help overcome barriers to abortion access in the United States.

22. Telemedicine for medication abortion is as safe and effective as in-person treatment.[18] The complication rate for medication abortion is exceedingly low (less than 0.5%), whether it is provided in-person or by telemedicine.[19] In our 2011 Iowa study, we investigated the effectiveness and acceptability of telemedicine for medication abortion compared to in-person medication abortions, and we found that the success rates were very similar: 98.7% for telemedicine patients and 96.9% for in-person patients.[20] No patient in this study required

[16] *Changes in Service Delivery Patterns After Introducing Telemedicine* at 73.
[17] Daniel Grossman et al., *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*, 118 Obstetrics & Gynecology 296, 300 (Aug. 2011) [hereinafter *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*]; *see also* Victoria A. Wade et al., *A Systematic Review of Economic Analyses of Telehealth Services Using Real Time Video Communication*, 10 BMC Health Serv. Res. 233 (2010) [hereinafter *A Systematic Review of Economic Analyses of Telehealth Services*].
[18] *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine* at 300; *see also A Systematic Review of Economic Analyses of Telehealth Services* at 233.
[19] *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine* at 300; *see also A Systematic Review of Economic Analyses of Telehealth Services* at 233.
[20] *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine* at 299.

hospitalization.[21] In fact, the overall rate of adverse events in the study was less than 0.3%.[22] Importantly, we found that telemedicine and in-person patients had no significant difference in the occurrence of adverse events.[23]

23. In our 2017 Iowa study, we compared the safety of medication abortion between patients receiving services by telemedicine and those having an in-person visit at Planned Parenthood of the Heartland clinics in Iowa from July 1, 2008, to June 30, 2015.[24] In this 7-year study, 8,765 medication abortions were performed with telemedicine, and 10,405 received an in-person appointment.[25] We found that medication abortion patients rarely experienced clinically significant adverse events (only 0.26% of the 19,170 patients). These adverse outcomes were uncommon with telemedicine (0.18% of telemedicine patients), and there were no reported deaths or cases requiring surgery among any of the medication abortion patients.[26] Indeed, there was no significant difference in the prevalence of adverse events between telemedicine and in-person patients.[27]

24. As an expert panel convened by the National Academies of Sciences, Engineering and Medicine in 2018 concluded, there is no medical need for medication abortion to be administered in the physical presence of a health care provider.[28] Screening women for contraindications and eligibility, providing counseling, and dispensing medication can be done with equal safety regardless of whether the physician is physically present in the room with the patient. Additionally, in the rare occasions when complications do arise, it would not matter

[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] Daniel Grossman and Kate Grindlay, *Safety of Medical Abortion Provided Through Telemedicine Compared With In Person*, 130(4) Obstetrics & Gynecology 778 (Oct. 2017).
[25] *Id.* at 780.
[26] *Id.*
[27] *Id.*
[28] NAS, *Safety and Quality of Abortion Care* at 79.

whether the patient obtained a medication abortion in-person or through telemedicine. This is so because any complications that do arise after medication abortion occur after the patient has left the clinic.

25. Additionally, the reported risks of medication abortion are low and similar in magnitude to the adverse effects of common prescriptions and over-the-counter medications.[29] As the National Academies of Sciences, Engineering, and Medicine found, when taken together with the Iowa study's findings, it appears that providing medication abortion in specific facilities or with an in-person visit with the clinician is not necessary to ensure safety, as the risks are essentially the same as common pharmaceuticals routinely dispensed in pharmacies and taken at home.[30]

26. Telemedicine for medication abortion has been used in Iowa since June 2008,[31] in Alaska since 2011,[32] Maine since 2016,[33] by one clinic in Illinois since 2016,[34] and most recently in Washington, Hawaii, and Oregon through the Gynuity TelAbortion Study.[35] Providers have found it easy to integrate the new technology for telemedicine into their clinic operations, as it requires the same processes and clinic flow as an in-person visit.[36] Providers using telemedicine

[29] *Id*. at 58.
[30] *Id.*
[31] *Changes in Service Delivery Patterns After Introducing Telemedicine* at 73-78.
[32] Kate Grindlay and Daniel Grossman, *Telemedicine Provision of Medical Abortion in Alaska: Through the Provider's Lens.* 23(7) J. Telemedicine Telecare 680 (Aug. 2017) [hereinafter *Telemedicine Provision of Medical Abortion in Alaska*].
[33] Sarah Boden, *Maine Follows Iowa's Lead on Telemed Abortion Iowa Public Radio*, Iowa Pub. Radio, http://www.iowapublicradio.org/post/maine-follows-iowas-lead-telemed-abortion#stream/0 (last visited Oct. 17, 2018).
[34] Angie Leventis Lourgos, *Illinois Clinic Provides Abortions Via Telemedicine, Which Provides Wider Access But Is Prohibited in 19 states*, chicagotribune.com (Jan. 19, 2018) http://www.chicagotribune.com/lifestyles/health/ct-met-telemedicine-abortion-illinois-20171220-story.html (last visited Oct 17, 2018); Julie Spitzer, *How One Illinois Clinic Provides Abortions Via Telemedicine*, Becker's Hospital Review, (Jan. 19, 2018), https://www.beckershospitalreview.com/telehealth/how-one-illinois-clinic-provides-abortions-via-telemedicine.html (last visited Oct. 17, 2018).
[35] Gyunity TelAbortion: The Telemedicine Abortion Study, http://telabortion.org/.
[36] *Telemedicine Provision of Medical Abortion in Alaska* at 682.

report that their interactions with the patients are essentially the same as an in-person visit.[37] Medication abortion through telemedicine is cost and medically effective, and acceptability is high among women who choose this model for treatment.[38] In fact, telemedicine patients are more likely to recommend the service to a friend than face-to-face patients.[39]

27. Telemedicine furthers public health because it improves access to early medication abortion in underserved areas.[40] The number of abortion providers has declined over the last three decades in the United States, resulting in greater distances and higher costs for some women to obtain treatment.[41] There are only three abortion providers in Kansas: Trust Women Wichita; Center for Women's Health in Overland Park; and Planned Parenthood (Overland Park and Wichita). [42] These abortion providers are clustered in two metropolitan areas, Overland Park and Wichita.

28. Telemedicine improves access for disproportionately affected poor women and those living in rural and underserved areas who are not readily able to travel.[43] In 2014, in the U.S., 90% of counties lacked an abortion provider and 39% of women of reproductive age lived in those counties and would have to travel to receive abortion care.[44] In Kansas, 97% of counties had no clinics that provided abortion care and 56% of women of reproductive age lived in one of those counties.[45] As a consequence, women in rural areas are affected the most. In fact, ACOG has

[37] *Id* at 683.
[38] *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine* at 300; *see also* Kate Grindlay, Kathleen Lane, and Daniel Grossman, *Women's and Providers' Experiences with Medical Abortion Provided Through Telemedicine: A Qualitative Study*, 23(2) Women's Health Issues 117-22 (Mar.-Apr. 2013) [hereinafter *Women's and Providers' Experiences with Medical Abortion*].
[39] *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine* at 300.
[40] *Id* at 296-300.
[41] *Women's and Providers' Experiences with Medical Abortion* at117-22.
[42] *State Facts about Abortion: Kansas*, Guttmacher Inst. (May 2018), https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-kansas#7.
[43] *Id.*
[44] *Id.*
[45] *Id.*

expressed ongoing concern over the lack of medical services available to women in rural communities, and has asked ob-gyns to "[f]oster and participate in efforts to utilize effective telemedicine technologies…to expand and improve services for rural women."[46]

29. Telemedicine facilitates a patient-centered approach to care, enabling women to be seen sooner, with greater choice in abortion procedure type, and to be closer to their home.[47] As a result of telemedicine in Alaska, providers were able to schedule additional appointments that better meet patients' needs and in turn allowed women to be seen at earlier gestational ages.[48] Telemedicine also expands access to abortion services by allowing clinics to provide more appointments with shorter wait times.[49] In contrast, before telemedicine, clinics in areas without or with few abortion providers had to transport doctors to the clinic. In Alaska, the need to transport physicians limited the clinic's ability to offer abortion services to once or twice a month.[50] This limitation increased the wait time for women to receive an abortion procedure, at times pushing women beyond the gestational limit for medication abortions.[51]

30. Between October 2009 and February 2010, we conducted a study in Iowa, in which we performed in-depth interviews with women receiving telemedicine and clinic staff involved in providing medication abortion through telemedicine.[52] The study showed that women opted for the telemedicine visit because of the close proximity, the reduced amount of time they

[46] *Committee on Health Care for Underserved Women*: *Health Disparities in Rural Women*, American College of Obstetricians and Gynecologists, Opinion Number 586 (Feb. 2014) (reaffirmed in 2016), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co586.pdf?dmc=1&ts=20181105T1932069692.
[47] *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine* at 300.
[48] *Telemedicine Provision of Medical Abortion in Alaska* at 681-682.
[49] *Id*.; *see also Women's and Providers' Experiences with Medical Abortion* at 117-22.
[50] *Telemedicine Provision of Medical Abortion in Alaska* at 681.
[51] *Telemedicine Provision of Medical Abortion in Alaska* at 681.
[52] *Women's and Providers' Experiences with Medical Abortion* at 118.

had to take off from work or school, the lower costs associated with travel, and because they did not have to explain the reason for traveling to a more distant location.[53]

31. In the same study, clinic staff cited numerous benefits to introducing telemedicine in their practice: physicians can reach more patients; greater efficiency of resources with women and providers no longer having to travel long distances, and fewer delays related to travel in severe weather.[54] The greatest perceived impact in the study was the enhanced access for their patients.[55]

32. We conducted another study in Iowa that assessed the effect of a telemedicine model providing medication abortion on service provided in Iowa clinics.[56] In Iowa, abortion access for women in more remote parts of the state increased with telemedicine.[57] Women living farther than 50 miles from the nearest clinic offering surgical abortion were more likely to obtain an abortion after the introduction of telemedicine in Iowa.[58] Telemedicine improved women's access to abortion care by expanding the number of clinics able to provide medication abortion and benefited patients by reducing travel distance.[59]

33. The same study suggests that women had a 46% greater likelihood of having an abortion at or before 13 weeks of gestation when obtaining abortion services after the introduction of telemedicine. [60] Because women often do not become aware that they are pregnant until about five weeks LMP or later, many women struggle to access care within the short window medication abortion is available. By providing more scheduling options and locations closer to women's homes, telemedicine allows women to access abortion services earlier in their pregnancies. As

[53] *Id.* at 118-19.
[54] *Id.* at 120.
[55] *Id.* at 120-21.
[56] *Changes in Service Delivery Patterns After Introducing Telemedicine*.
[57] *Id.* at 75.
[58] *Id.*
[59] *Id* at 76.
[60] *Id*. at 75.

explained, the earlier an abortion in performed, the safer it is for the woman. [61] Thus, access to early abortion care benefits the public health as reducing second trimester abortions helps to reduce the rare health risks associated with later abortions.

34. Kansas has utilized telemedicine since 1991, providing clinical consultations, follow-up care and medication management in more than thirty medical specialties, including autism diagnosis, cardiology, oncology/hematology, pain management, pediatrics, psychiatry, and psychology.[62] Neurologists use telemedicine to diagnose stroke patients at Kansas hospitals that do not have a neurologist available, based on imaging scans, and to prescribe appropriate treatment, including IV-tPA, a life-saving treatment for ischemic stroke victims that also risks intracranial hemorrhage and major systemic hemorrhage.[63] Additionally, Newton Medical Center uses a robot on a rolling stand equipped with a digital stethoscope and other diagnostic equipment, and a videoconferencing monitor and camera to treat patients in its general inpatient setting.[64]

35. Thus, in all medical contexts except abortion, Kansas allows physicians to use telemedicine to provide treatment, including dispensing prescription medications, that presents just as much risk or more risk to the patient as medication abortion.

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[61] *Comparative Safety of Legal Induced Abortion and Childbirth* at 216.
[62] *KU Center for Telemedicine & Telehealth*, KU Center for Telemedicine & Telehealth, http://www.kumc.edu/community-engagement/ku-center-for-telemedicine-and-telehealth.html (last visited Nov. 1, 2018); *see also Clinical Services Overview*, KU Center for Telemedicine & Telehealth, http://www.kumc.edu/community-engagement/ku-center-for-telemedicine-and-telehealth/clinical-services.html (last visited Nov. 1, 2018).
[63] *WesleyCare Virtual Network*, Wesley Healthcare, https://wesleymc.com/service/wesley-telemedicine-network (last visited Nov. 1, 2018); *see also Newton Medical Center Launches Telestroke Program*, Newton Medical Center (2017), https://www.newtonmed.com/newton-medical-center-launches-telestroke-program (last visited Nov. 1, 2018); Daniel J. Miller, MD, Jennifer R. Simpson, MD, and Brian Silver, MD, *Safety of Thrombolysis in Acute Ischemic Stroke: A Review of Complications, Risk Factors, and Newer Technologies*, 1(3) The Neurohospitalist 138 (Jul. 2011).
[64] *Newton Medical Center Implements Telemedicine Program*, Newton Medical Center (2016), https://www.newtonmed.com/newton-medical-center-implements-telemedicine-program/ (last visited Nov. 1, 2018).

36. Kansas legislation to ban telemedicine abortion unnecessarily restricts abortion service providers' ability to provide services to women, potentially increasing risk and adversely affecting public health by infringing upon a woman's right to access abortion services.[65]

37. For all of the foregoing reasons, it is my opinion that Section 6 of the Telemedicine Act and the medication in-person requirement, if no longer enjoined, will diminish women's access to care and will expose them to increased medical risk by delaying women's access to early abortion care and by preventing some women from accessing medication abortion entirely.

[65] *Changes in Service Delivery Patterns After Introducing Telemedicine* at 73-78; *see also Risk Factors for Legal Induced Abortion* at 279-37.

Signed this 26th day of February 2019.

Daniel Grossman, MD

CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT **CIVIL CODE § 1189**

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of Alameda)

On Feb 26, 2019 before me, JOSE HERNALDO AGREDANO REYNOSO, NOTARY PUBLIC,
Date *Here Insert Name and Title of the Officer*

personally appeared Daniel Grossman,
Name(s) of Signer(s)

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/~~are~~ subscribed to the within instrument and acknowledged to me that he/~~she/they~~ executed the same in his/~~her/their~~ authorized capacity(~~ies~~), and that by his/~~her/their~~ signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____
Signature of Notary Public

JOSE HERNALDO AGREDANO REYNOSO
COMM. #2139409
NOTARY PUBLIC - CALIFORNIA
ALAMEDA COUNTY
My Commission Expires 01/07/2020

Place Notary Seal Above

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☐ Individual ☐ Attorney in Fact
☐ Trustee ☐ Guardian or Conservator
☐ Other: _____
Signer Is Representing: _____

Exhibit 2

IN THE THIRD JUDICIAL DISTRICT
DISTRICT COURT, SHAWNEE COUNTY, KANSAS
DIVISION 3

TRUST WOMEN FOUNDATION INC. d/b/a SOUTH WIND WOMEN'S CENTER d/b/a TRUST WOMEN WICHITA, Plaintiff, v. MARC BENNETT, in his official capacity as District Attorney for Sedgwick County, Kansas; KATHLEEN SELZER LIPPERT, in her official capacity as the Executive Director of the Kansas Board of Healing Arts; and ROBIN D. DURRETT, in her official capacity as President of the Kansas Board of Healing Arts; and DEREK SCHMIDT, in his official capacity as Attorney General of the State of Kansas, Defendants.	)	Case No. 2019-CV-60

AFFIDAVIT OF JULIE BURKHART IN SUPPORT OF MOTION FOR TEMPORARY INJUNCTION AND TEMPORARY RESTRAINING ORDER

JULIE BURKHART, hereby declares under penalty of perjury that the following statements are true and correct:

1. I am the founder and CEO of the Trust Women Foundation ("Trust Women"). Trust Women operates three clinics, which offer high-quality reproductive health care, including abortion, transgender care, HIV/AIDS testing, well woman exams, and contraceptive services, providing access for those in underserved communities. Trust Women opened its first clinic, Trust

Women South Wind Women's Center (doing business as "Trust Women Wichita"), in Wichita, Kansas on April 3, 2013. Trust Women opened a second clinic in Oklahoma, City, Oklahoma ("Trust Women Oklahoma City") in 2016 and a third clinic in Seattle, Washington ("Trust Women Seattle") in 2017.

2. All the Trust Women clinics, including Trust Women Wichita, are members of the National Abortion Federation ("NAF"), the largest professional association of abortion practitioners in the United States. NAF regularly performs inspections of the clinics to ensure compliance with NAF's clinical policy guidelines.

3. Trust Women Wichita has also been licensed by the Kansas Department of Health and Environment ("KDHE") as an ambulatory surgical center since July 2014. Trust Women Wichita is subject to KDHE inspection, submits quarterly Risk Management Reports to KDHE, provides KDHE with an annual renewal report each year, and has been issued a new license by KDHE annually.

4. Trust Women Wichita is open to patients Tuesday through Friday. Throughout the week, a nurse practitioner is available to provide reproductive healthcare (other than abortion), transgender care, HIV/AIDS testing, well woman exams, and contraceptive services. As discussed more fully below, prior to telemedicine, Trust Women Wichita only offered abortion care on Thursdays and Fridays. Trust Women Wichita provides medication and surgical first trimester abortions as well as second trimester abortions up until 21 weeks, 6 days of pregnancy, as measured from the first day of the woman's last menstrual period ("LMP").

5. At Trust Women Wichita, the vast majority of abortion patients are in the first trimester. In 2018, 84% of the clinic's patients were in the first trimester. During the first trimester, two methods of abortion may be available to women: medication abortion and surgical

aspiration abortion. A first trimester abortion at Trust Women Wichita costs between $600 and $750. Second trimester abortions at the clinic range in cost from $750 to $2,350.

6. Patients at Trust Women Wichita seek abortion care for myriad reasons. Some women simply do not feel it is the right time for them to have a child. Many already have children—approximately 70% of the clinic's abortion patients have at least one child—and do not have the ability to provide the care necessary for another child. Some may not have the financial resources to care for a child—approximately 30% of the clinic's patients receive NAF or other funding assistance. To qualify for this funding, a patient must live at or below the federal poverty line. Others may have become pregnant as a result of sexual assault and do not want to carry the pregnancy to term. Still others may have medical complications that make it dangerous for them to carry a pregnancy to term. Others are in college or graduate school and wish to continue their education and ensure their financial security before having a child. Some patients seek abortion because they are in abusive relationships. Whatever the reason the clinic's patients are seeking an abortion, the clinic's goal is to provide this necessary care professionally, safely, and free from judgment.

7. I submit this affidavit in support of Plaintiff's Motion for a Temporary Injunction and Temporary Restraining Order to enjoin enforcement of K.S.A. § 65-4a10 (the "medication in-person requirement") and Sections 6 and 7 of the Kansas Telemedicine Act, KSA §§40-2,210-40-2,216 ("the Act"). I understand that Section 6 of the Act, when read in conjunction with the medication in-person requirement, prohibits the use of telemedicine for the delivery of any abortion procedure, including medication abortion. It is also my understanding that although the medication in-person requirement is currently enjoined, Attorney General Schmidt has filed papers to lift the injunction, has appealed a ruling that the medication in-person requirement is currently

enjoined, and has argued that the District Attorney for Sedgwick County and the Board of Healing Arts are free to enforce the act.

8. In order to better serve our patients' needs, on October 13, 2018, Trust Women Wichita began to offer medication abortion using telemedicine. With the introduction of telemedicine, Trust Women Wichita expanded access to medication abortion, and was able to offer the service more days per week with expanded hours. Even though the telemedicine option has been a safe and effective option for our patients, Trust Women ceased offering it to our clients due to concerns that the District Attorney of Sedgwick County and/or the Board of Healing Arts would seek to enforce the medication in-person requirement.

9. Trust Women Wichita used telemedicine to expand access to medication abortion by using physicians located out of state. Under Trust Women Wichita's initial telemedicine efforts, described more fully below, patients' appointments occurred at the clinic in Wichita with the physicians participating using videoconferencing. Trust Women Wichita intended to expand its use of telemedicine to provide medication abortion to women who live in more rural areas and who have to travel significant distances to access abortion services, by offering telemedicine services closer to these women's homes. However, if medication in-person requirement is no longer enjoined, we will be prohibited from offering medication abortion services via telemedicine to any of our patients, and those in remote locations will continue to have to travel significant and burdensome distances to our facility in Wichita in order to access care.

I. Medication Abortion Access at Trust Women Wichita Before Telemedicine

10. Currently, Trust Women Wichita offers medication abortion up to 10 weeks LMP. The regimen used at Trust Women involves two medications, mifepristone and misoprostol, which taken together will result in the termination of an early pregnancy. The patient takes the

mifepristone at the clinic. The patient then takes the misoprostol 24 to 36 hours later outside of the clinic.

11. Medication abortion is incredibly safe and 95 percent effective. Trust Women Wichita has provided medication abortion since it opened in 2013, and the clinic's safety record has been excellent, with not a single reportable incident since opening.

12. Many of our patients strongly prefer medication abortion to surgical abortion for a variety of reasons. Some women prefer medication abortion because it allows them to complete the abortion in private or allows them to feel more in control of the procedure. For others, medication abortion may provide them with the flexibility they need to fit the abortion into their schedules. Medication abortion can also be disguised as a miscarriage, which allows women to conceal the procedure from disapproving partners, family, or friends. This is a particular benefit for women who may be victims of domestic violence who are trying to conceal the abortion from their abusive partners. Likewise, medication abortion may be preferred by women who are victims of sexual assault because it avoids any re-traumatization that could occur with a surgical abortion. Medication abortion may also be medically indicated for some women for a variety of reasons. At Trust Women Wichita in 2018, almost half of our abortion patients had a medication abortion. And among those for whom medication abortion was an option (those whose pregnancies were before 10 weeks LMP), nearly two-thirds chose medication abortion over surgical abortion.

13. Prior to founding Trust Women, I worked closely for many years as an adviser to Dr. George Tiller, who provided abortion care in Wichita, Kansas until he was murdered in 2009. Based on my first-hand experience working closely with abortion providers in Kansas for more than 20 years, individuals involved in abortion care in Kansas are ostracized by the mainstream medical community in our state and are targeted for harassment and violence. Additionally, Trust

Women Wichita regularly has protesters outside the clinic that harass staff, vendors, and patients. The protesters keep binders to take down the license plate number, make, model, and color of the clinic staff's, vendors', and patients' cars. To cope with this harassment, the clinic has a security guard on the premises 24 hours each day and numerous security cameras.

14. This atmosphere of stigma and harassment makes it extremely difficult to recruit and hire new physicians—particularly those that reside in the state. All of this creates an extremely hostile environment for anyone involved in abortion care within Kansas.

15. Prior to opening Trust Women Wichita, I made extensive efforts to recruit and hire local providers, but I was ultimately unable to find any local physicians who were willing to provide abortion care at the clinic. Currently, none of the physician who provide abortion care at Trust Women Wichita reside in Kansas, let alone the metropolitan Wichita area.

16. Given the dearth of local physicians willing to provide care, Trust Women Wichita flies a physician into Wichita to provide abortion services on Thursdays and Fridays. As a result the clinic is only able to provide abortion services on those two days.

17. Additionally, at times, our physicians' planes have been delayed or cancelled. Without telemedicine, if the physician could not reach the clinic, we were forced to cancel and reschedule all abortion appointments—including those for medication abortion, delaying our patients' access to this time-sensitive care. With telemedicine, even if a physician's travel plans are disrupted, we can continue to provide medication abortion care even though the physician is not physically present in the clinic.

18. Because of the shortage of abortion providers, as well as other obstacles to obtaining care, it can be extremely difficult for patients to access abortion care in Kansas. Many of our patients have very limited incomes, and Kansas law prohibits both public and most private

insurance from covering the procedure. It is also difficult for many to visit an abortion clinic during normal business hours due to demanding and unpredictable work schedules, school, lack of childcare, and other existing family obligations. Some may also be in abusive relationships and have controlling partners from whom they need to conceal the procedure.

19. Further, all three abortion providers in Kansas are either in the Wichita or Kansas City metropolitan areas. There are large portions of Kansas, in particular in the western half of the state, that lack any abortion provider. As a result, patients from western Kanas must travel at least 180 miles to reach the nearest abortion provider.[1] Approximately half of Trust Women Wichita's abortion patients live outside of the metropolitan area. More than 10% of Trust Women Wichita's patients travel from western Kansas to receive care at the clinic. While arranging transportation can be difficult under any circumstances, for many of these women, it can be a nearly insurmountable obstacle. All the obstacles women normally face when accessing abortion care—such as securing time off work, arranging for child care or coverage for other existing family obligations, financing and finding transportation, raising funds for the procedure—are only exacerbated by the greater distance, and therefore time, it requires to travel to the clinic. In the past, we have had women hire cars or take taxis, who once in Wichita, refuse to take our patients to the clinic. Other patients have taken lengthy bus rides to Wichita, only to find themselves stranded when they get here with no means of getting from the bus station to the clinic.

20. Despite Trust Women Wichita's best efforts, the clinic's inability to provide services more than two days a week, at times, limits women's ability to access abortion care at our clinic. Many women only have limited days off work and cannot easily adjust their schedules to

[1] Jonathan M. Bearkak, Kristen Lagasse Burke & Rachel K. Jones, *Disparities and Change over Time in Distance Women Would Need to Travel to Have an Abortion in the USA: A Spatial Analysis*, 2(11) The Lancet Pub. Health e493, e497 (Nov. 2017), https://www.thelancet.com/action/showPdf?pii=S2468-2667%2817%2930158-5.

visit the clinic on these days during normal business hours, which can lead to delays accessing care. As a result, some women may be forced to undergo a surgical abortion because they are unable to visit the clinic within the timeframe necessary for medication abortion. For other women, the clinic's limited appointment schedule may prevent them from accessing abortion care at all.

II. Medication Abortion Access at Trust Women Wichita with Telemedicine

21. On October 13, 2018, Trust Women Wichita began providing medication abortion through its telemedicine pilot program. Under the telemedicine pilot program, Trust Women Wichita has the potential to offer medication abortion appointments Monday through Saturday, with expanded clinic hours each day, depending on patient need and physician availability. Trust Women Wichita has existing relationships with three physicians who reside out of state and are licensed in Kansas, who are available to provide medication abortion using telemedicine. Telemedicine allows these physicians to provide medication abortion to patients at Trust Women Wichita without traveling to Kansas by connecting with patients on their computers, enabling them to provide services on an expanded and more flexible schedule. Telemedicine thus enables Trust Women Wichita to provide abortion care to women otherwise unable to visit the clinic on Thursdays and Fridays or during normal business hours and to expand the number of available appointments for medication abortion.

22. While patients must still travel to the clinic under the telemedicine pilot program, Trust Women Wichita intends to expand its use of telemedicine so that women living great distances from the clinic may access medication abortion closer to their homes and no longer have to drive hundreds of miles to Wichita. Trust Women Wichita is currently exploring numerous options, including renting medical office space in remote areas and utilizing a mobile medical unit that could travel to different remote areas where care is needed.

23. Staff members of Trust Women Wichita have attended informational meetings and national conferences that focus on mobile and remote healthcare to inform these efforts, and the clinic has been developing plans to extend our telemedicine services.

24. In addition to expanding appointment access, under the telemedicine pilot program, Trust Women Wichita can significantly streamline the time required for medication abortion appointments. Due to wait times for physicians throughout the process, non-telemedicine medication abortion appointments can take 6 to 8 hours. These wait times prolong the time a patient must spend in the clinic, forcing them to take more time off work or school, requiring potentially significant hours of childcare, and perhaps hindering a patient's ability to keep the procedure confidential.

25. Based on our experience with telemedicine at Trust Women Seattle, the average appointment time for medication abortion using telemedicine is between 1.5 to 2 hours. Based on our experience with the telemedicine pilot program at Trust Women Wichita, wait times were significantly reduced and generally took 2 hours or less.

26. If not for the uncertainty regarding whether the District Attorney of Sedgwick County and the Board of Healing Arts will seek to enforce the medication in-person requirement, Trust Women Wichita would currently be offering medication abortions via telemedicine to eligible patients on Saturdays, on additional week days, and during extended hours. In fact, since the clinic ceased providing medication abortion via telemedicine, it has received continued interest in the telemedicine program as well as patient requests to schedule medication abortions via telemedicine on Mondays and Saturdays – requests the clinic has not been able to fulfill due to Defendants' position.

III. Protocol for Provision of Medication Abortion Using Telemedicine

27. The provision of medication abortion under the telemedicine pilot program at Trust Women Wichita is nearly identical to the in-person provision of medication abortion. When a patient seeking an abortion at Trust Women Wichita calls to schedule an appointment, the schedulers screen the patient to see which abortion procedures are available to her. If she is eligible for medication abortion, and chooses this option, she is scheduled for a medication abortion appointment at the clinic.

28. The appointment will be scheduled at least 24 hours from the patient's receipt of the state-mandated information.

29. When the patient arrives at the clinic for the appointment, the patient fills out more informational and consent forms. The clinic then performs labs on the patient (typically a RH/HgB blood test) and takes the patient's vital signs (typically blood pressure, heart rate, temperature, and respiration) and the results are entered into the patient's electronic medical record. All of this occurs in exactly the same manner, regardless of whether it is an in-person or telemedicine medication abortion appointment.

30. Once these tests are complete, the patient is then seen for an ultrasound. A trained clinician performs the ultrasound and uploads the ultrasound images to the patient's electronic medical record. During the ultrasound, the remote physician is present and participates using a HIPAA-compliant videoconferencing application designed for telemedicine. Throughout the ultrasound, the physician can see the patient and may answer any questions that arise.

31. The physician, working remotely, reviews the patients' medical history, lab results, vital signs, and ultrasound images through the clinic's electronic medical record system and confirms the patient is eligible for medication abortion. Once the physician's review is complete,

the physician meets privately with the patient via videoconferencing. During this meeting, the physician confirms the patient's medical history and the patient is given an opportunity to ask any questions.

32. After this private meeting, a patient care coordinator at the clinic meets with the patient for further screening and consultation. A follow-up appointment two to three weeks later is also scheduled during this meeting. This private meeting with a patient care coordinator occurs in exactly the same manner regardless of whether it is an in-person or telemedicine medication abortion appointment.

33. After the patient's screening and consultation with the patient care coordinator, and after at least 30 minutes have elapsed since the patient's private meeting with the physician, the patient is moved to the recovery room. In the recovery room, a new videoconferencing session is initiated between the patient and the physician. At this time, the physician confirms the patient is ready to proceed with the medication abortion and instructs a licensed medication aid to provide the two medications to the patient. All while the physician observes via videoconferencing, the patient takes the mifepristone pill immediately at the clinic and is given detailed instructions on how to take the misoprostol pills. The patient is then discharged from the clinic.

34. The patient returns for a follow-up appointment two to three weeks later. At the follow-up appointment, a pregnancy test and, if necessary, an ultrasound is performed to confirm that the medications successfully terminated the pregnancy. All medication abortion follow-up appointments are scheduled for days when a physician is at the clinic so that a patient may receive a suction procedure in the clinic on that same day, in the rare event the pregnancy was not successfully terminated.

35. The protocol for the in-person provision of medication abortion varies minimally in that the physician typically will perform the ultrasound and conduct the private meeting with the patient simultaneously. And, the physician will be physically present in the recovery room when the patient receives the medications and ingests the first pill. Otherwise, there are no differences between the in-person provision of medication abortion and medication abortion under the clinic's telemedicine pilot program.

IV. Experiences in Wichita and Seattle Show Medication Abortion Can Be Provided Safely and Effectively Using Telemedicine.

36. To date, Trust Women Wichita has received universally positive feedback from patients who have received medication abortion via telemedicine. Trust Women Seattle began to offer medication abortion via telemedicine in September 2018 using a nearly identical protocol. Similarly, Trust Women Seattle has received universally positive feedback from its patients who have received medication abortion via telemedicine.

37. For all these reasons, I believe that, if the medication in-person requirement is no longer enjoined it, as well as Section 6 of the Telemedicine Act, will further limit access to abortion in Kansas, without providing any medical benefit to patients. Prohibiting our clinic from offering abortion via telemedicine will be detrimental to Kansas women, as it further stigmatizes abortion care, needlessly prevents our patients from being able to take advantage of telemedicine, and hinders our ability to provide care in underserved, rural locations.

Signed this 13 day of Feburary 2019.

Julie Burkhart

LINDA DODDS
NOTARY PUBLIC
OFFICIAL SEAL
STATE OF KANSAS
MY APPOINTMENT EXPIRES
Date: 9-29-19

Exhibit 3

IN THE THIRD JUDICIAL DISTRICT
DISTRICT COURT, SHAWNEE COUNTY, KANSAS
DIVISION 3

TRUST WOMEN FOUNDATION INC. d/b/a SOUTH WIND WOMEN'S CENTER d/b/a TRUST WOMEN WICHITA, Plaintiff, v. MARC BENNETT, in his official capacity as District Attorney for Sedgwick County, Kansas; KATHLEEN SELZER LIPPERT, in her official capacity as the Executive Director of the Kansas Board of Healing Arts; and ROBIN D. DURRETT, in her official capacity as President of the Kansas Board of Healing Arts; and DEREK SCHMIDT, in his official capacity as Attorney General of the State of Kansas, Defendants.	)	Case No. 2019-CV-60

AFFIDAVIT OF COLLEEN MCNICHOLAS, D.O., M.S.C.I., F.A.C.O.G. IN SUPPORT OF MOTION FOR TEMPORARY INJUNCTION AND TEMPORARY RESTRAINING ORDER

COLLEEN P. MCNICHOLAS, D.O., M.S.C.I., F.A.C.O.G., hereby declares under penalty of perjury that the following statements are true and correct:

1. I am an obstetrician and gynecologist certified by the American Board of Obstetrics and Gynecology since 2011. I am licensed to practice in Missouri, Kansas, Oklahoma, and Washington. At present, I am an Associate Professor at the Washington University School of Medicine in St. Louis, Missouri, in the Department of Obstetrics and Gynecology's Division of

Family Planning. I am also the Director of the Ryan Residency Collaborative between Oklahoma University and the Washington University School of Medicine, which provides formal training in abortion and family planning for residents in obstetrics and gynecology, and the Co-Director of the Family Planning Fellowship at Washington University. Through my various academic roles, I have taught numerous medical students, trained nearly 250 residents in family planning, and a number of family planning fellows. I also have considerable experience in the provision of abortion in the outpatient setting, including in Kansas, as I am currently the Medical Director of Trust Women Wichita where I provide medication abortions among other procedures.

2. I completed my residency in obstetrics and gynecology at Washington University School of Medicine in 2011. I then completed a two-year fellowship there in family planning. My *curriculum vitae*, which sets forth my experience and credentials more fully, is annexed hereto as Exhibit 1.

3. My practice throughout all my positions focuses on providing patients with full-spectrum reproductive health-care, including second-trimester abortion, medical and surgical abortion in the first trimester, and contraceptive care. I feel that it is tremendously important to provide these necessary services to women because they enable women to control their reproductive lives, ensure they parent when they choose to do so, and participate fully in society. My ultimate goal is always to provide these services in a safe and compassionate manner.

4. I submit this declaration in support of Plaintiff's Motion for Temporary Injunction and Temporary Restraining Order to enjoin enforcement of K.S.A. § 65-4a10 (the "medication in-person requirement") as well as Sections 6 and 7 of the Kansas Telemedicine Act, K.S.A. §§40-2,210-40-2,216 (collectively, the "Challenged Laws"). I understand that the Challenged Laws, if enforceable, prohibit the use of telemedicine for the delivery of any abortion procedure, including

medication abortion. While it is my understanding that the medication in-person requirement is already enjoined, I have been informed that Trust Women has filed this motion out of an abundance of caution because the defendants in this case have refused to confirm they will not seek to enforce this provision. If the Challenged Laws are enforceable and are not preliminarily enjoined, Trust Women Wichita will be unable to resume offering medication abortion through telemedicine, unnecessarily and detrimentally impeding patient access without any corresponding benefit to patient health.

5. My opinions are based on my personal knowledge, as well as my training, education, clinical experience, ongoing review of the relevant professional literature, discussions with colleagues, and attendance at conferences in the fields of obstetrics, gynecology, and gynecological surgery.

I. Abortion, including Medication Abortion, is Safe and Effective.

6. Abortion is one of the safest and most common medical procedures in contemporary medical practice.[1] Complication rates for abortion are lower than those for colonoscopies, plastic surgery, dental procedures, and adult tonsillectomies.[2] In fact, one of the most comprehensive studies found that major complication rates (defined as requiring hospital admission, surgery, or blood transfusion) among 54,911 abortions occurred in only .23 percent of cases.[3]

[1] National Academies of Science, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States*, at 77 (2018) [hereinafter NAS, *Safety and Quality of Abortion Care*], http://nap.edu/24950 ("The clinical evidence makes clear that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective.").
[2] *Id.* at 74-75.
[3] Ushma D. Upadhyay, PhD, MPH, et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125(1) Obstetrics & Gynecology 175, 181 (Jan. 2015).

7. Abortions are performed either surgically or medically. Surgical abortion requires no cutting or incision and is accomplished through the use of suction and/or instruments to evacuate the contents of the uterus and may involve the use of anesthesia or sedation.

8. Medication abortion involves safely and effectively terminating a pregnancy, non-surgically, through a combination of two prescription medications: mifepristone and misoprostol. Mifepristone works by blocking the hormone progesterone, which is necessary to maintain pregnancy. Misoprostol then causes the uterus to contract and expel its contents, generally within hours, thereby completing the abortion. Medication abortion requires no anesthesia or sedation.

9. Medication abortion has been available in the United States for nearly two decades.[4] The FDA first approved mifepristone and misoprostol for medication abortion in 2000. In March of 2016, the FDA reapproved the use of mifepristone and misoprotol to terminate a pregnancy, updating the labeling to align with standard medical practice and reaffirming that medication abortion is extremely safe and highly effective.[5] A recent analysis of abortion care in the United States performed by the National Academies of Science, Engineering, and Medicine concluded that medication abortion is extremely safe and involves little risk with complications occurring in less than one percent of patients.[6]

10. Currently at Trust Women Wichita, medication abortion is available to women up to 10 weeks of pregnancy, as measured by best obstetric dating either from the first day of the last menstrual period ("LMP") or by ultrasound confirmation of gestational age.

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[4] *Medication Abortion*, Guttmacher Inst. (2018), https://www.guttmacher.org/evidence-you-can-use/medication-abortion (last visited Nov. 1, 2018).
[5] *The Public Health Implications of the FDA Update to the Medication Abortion Label*, Guttmacher Inst. (2016), https://www.guttmacher.org/article/2016/06/public-health-implications-fda-update-medication-abortion-label (last visited Nov. 1, 2018).
[6] NAS, *Safety and Quality of Abortion Care* at 55 (citing several studies).

11. In my experience, among women for whom medication abortion is an option (generally those whose pregnancies are before 10 weeks LMP), many prefer medication abortion over surgical abortion. For some women, medication abortion offers important advantages over surgical abortion. Many women prefer medication abortion because they can complete the process in the privacy of their homes, with the company of loved ones, at a time of their choosing, and because it feels more natural, like a miscarriage.

12. There are women who choose medication abortion because they fear a procedure involving surgical instruments. Women who are victims of rape, or women who have experienced sexual abuse or molestation, may choose medication abortion because they want to avoid any trauma caused by having instruments placed in their vagina. Medication abortion may help these women feel more in control of the experience.

13. Medication abortion is a better option than surgical abortion for women with certain medical conditions. For example, medication abortion is a significantly safer option, with a lower risk of complications and failure than surgical abortion, for women with: anomalies of the reproductive and genital tract, such as large uterine fibroids; female genital mutilation; vaginismus, or cervical stenosis; as well as severe obesity or an extremely flexed uterus. All of these conditions make it difficult to access the pregnancy inside the uterus as part of a surgical abortion and make medication abortion a safer option for these patients.

14. At Trust Women Wichita in 2018, nearly half of the abortions were medication abortions. Amongst women for whom medication abortion was an option (those whose pregnancies were before 10 weeks LMP), almost two-thirds chose medication abortion over surgical abortion.

II. Telemedicine Benefits Patients by Expanding Access to Healthcare

15. Telemedicine is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across distance.[7] Telemedicine has been widely adopted across the medical spectrum to expand access to necessary medical care.[8] Telemedicine can enhance access by increasing the number of available providers and by reducing costs and logistical barriers.[9]

16. This is particularly relevant in states, like Kansas, where significant portions of the population reside in rural areas that lie great distances from healthcare providers.[10] For Kansans living in rural parts of the state, telemedicine can make the difference between an individual accessing or forgoing needed healthcare. In February 2014, the American College of Obstetricians and Gynecologists ("ACOG"), Committee on Health Care for Underserved Women, issued an opinion highlighting the health disparities between rural and urban women. One of ACOG's specific recommendations for tackling these disparities is to "[f]oster and participate in efforts to utilize effective telemedicine technologies (in accordance with state regulations) to expand and improve services for rural women."[11]

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[7] NAS, *Safety and Quality of Abortion Care* at 57; *see also* Dan Grossman et al., *Changes in Service Delivery Patterns After Introducing Telemedicine Provision of Medical Abortion in Iowa*, 103(1) Am. J. Pub. Health 73 (Jan. 2013).

[8] Dan Grossman et al., *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*, 118 Obstetrics & Gynecology 296, 300 (Aug. 2011); *see also* Victoria A. Wade et al., *A Systematic Review of Economic Analyses of Telehealth Services Using Real Time Video Communication*, 10 BMC Health Serv. Res. 233 (2010).

[9] Dan Grossman, et al., *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*, 118 Obstetrics & Gynecology 296, 300 (Aug. 2011); *see also* Victoria A. Wade et al., *A Systematic Review of Economic Analyses of Telehealth Services Using Real Time Video Communication*, 10 BMC Health Serv. Res. 233 (2010).

[10] Jonathan M. Bearkak, Kristen Lagasse Burke and Rachel K. Jones, *Disparities and Change over Time in Distance Women Would Need to Travel to Have an Abortion in the USA: A Spatial Analysis*, 2(11) The Lancet Pub. Health e493, e497 (Nov. 2017), https://www.thelancet.com/action/showPdf?pii=S2468-2667%2817%2930158-5.

[11] *Committee on Health Care for Underserved Women*: *Health Disparities in Rural Women*, American College of Obstetricians and Gynecologists, Opinion Number 586 (Feb. 2014) (reaffirmed in 2016), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co586.pdf?dmc=1&ts=20181105T1932069692.

17. I am aware that Kansas has been providing healthcare through the use of telemedicine at least since 1991.[12] Both the University of Kansas and Newton Medical Center in Newton, Kansas, have telemedicine programs. Additionally, WesleyCare Virtual Network connects neurologists with patients in rural areas of Kansas via telemedicine. The University of Kansas Center for Telemedicine and Telehealth promotes the use of telemedicine in more than thirty medical specialties,[13] and in Newton, telemedicine is utilized to treat both patients in its general inpatient setting as well as stroke victims in need of rapid diagnosis and treatment.[14] The WesleyCare website indicates that in Kansas, neurologists—through telemedicine—prescribe IV-tPA to stroke patients in hospitals that do not have neurologists on staff.[15] While IV-tPA is potentially life-saving for patients who suffer an ischemic stroke, it is potentially fatal for hemorrhagic stroke patients.[16]

18. In other rural states, like Arkansas, telemedicine has also been used to improve high-risk obstetrical care. For example, the University of Arkansas for Medical Sciences ("UAMS") offers a high-risk obstetrical telemedicine program—the Antenatal and Neonatal Guidelines, Education, and Learning System (ANGELS)—to help combat rural health disparities. As a largely rural state, Arkansas has vast areas that are medically underserved. It also has few maternal-fetal medicine specialists practicing outside of UAMS, which is located in one of the few

[12] *KU Center for Telemedicine & Telehealth*, KU Center for Telemedicine & Telehealth, http://www.kumc.edu/community-engagement/ku-center-for-telemedicine-and-telehealth.html (last visited Nov. 1, 2018).
[13] *Clinical Services Overview*, KU Center for Telemedicine & Telehealth, http://www.kumc.edu/community-engagement/ku-center-for-telemedicine-and-telehealth/clinical-services.html (last visited Nov. 1, 2018).
[14] *Newton Medical Center Implements Telemedicine Program*, Newton Medical Center (2016), https://www.newtonmed.com/newton-medical-center-implements-telemedicine-program/ (last visited Nov. 1, 2018); *Newton Medical Center Launches Telestroke Program*, Newton Medical Center (2017), https://www.newtonmed.com/newton-medical-center-launches-telestroke-program (last visited Nov. 1, 2018).
[15] *WesleyCare Virtual Network*, Wesley Healthcare, https://wesleymc.com/service/wesley-telemedicine-network (last visited Nov. 1, 2018).
[16] *See* Joanna M. Wardlaw et al., *Recombinant Tissue Plasminogen Activator for Acute Ischaemic Stroke: An Updated Systematic Review and Meta-Analysis*, 379(9834) The Lancet 2364 (Jun. 23, 2012).

urban areas of the state. Utilizing one of the largest telehealth networks in the nation, ANGELS extends the expertise of Arkansas' few board-certified maternal-fetal medicine specialists into the hands of Arkansas' community providers and patients through telemedicine.[17]

19. These programs highlight both the safety and health benefits of telemedicine, even for care that is substantially more complex, with significantly greater associated risks, than medication abortion. Particularly in Kansas, where telemedicine has been utilized to provide healthcare for over 27 years, and for treatment of a serious and life-threatening condition such as a stroke, there is no medical basis to prohibit the provision of medication abortion through telemedicine; it is a treatment that is as safe or safer than that already provided via telemedicine in Kansas.

III. The Provision of Medication Abortion through Telemedicine Is Safe.

20. I have reviewed and approved the medication abortion telemedicine protocols in place at Trust Women Wichita. I believe that under these protocols, telemedicine can be used to safely provide medication abortion. Because medication abortion is a non-invasive procedure, the delivery of care does not require in-person examination by a physician.

21. Providing medication abortion via telemedicine is consistent with the current medication indications described in the FDA label for mifepristone.[18] ACOG has also concluded that medication abortion can be provided safely and effectively with a high level of patient satisfaction using telemedicine.[19]

[17] Curtis Lowery, M.D., *Telehealth: A New Frontier in OB/GYN*, Contemp. OB/GYN, Aug. 2018, at 16-18, 34-35.
[18] *The Public Health Implications of the FDA Update to the Medication Abortion Label*, Guttmacher Inst. (2016).
[19] *Medical Management of First-Trimester Abortion*, American College of Obstetricians and Gynecologists, Practice Bulletin No. 143 (Mar. 2014) (reaffirmed 2016), https://www.acog.org/-/media/Practice-Bulletins/Committee-on-Practice-Bulletins----Gynecology/Public/pb143.pdf.

22. At Trust Women Wichita, prior to proceeding with medication abortion, a physician reviews a patient's electronic medical record, including ultrasound scans; conducts a private consultation with the patient; and instructs that the medications be provided to the patient. None of these tasks require a physician to be in the same physical location as the patient or to conduct an in-person examination. In my opinion, being physically remote from the patient does not diminish the quality of care a physician is able to provide in the medication abortion context.

23. In addition to reviewing the protocols in place at Trust Women Wichita, and drawing from personal experience providing medication abortion, I have also reviewed numerous studies that show medication abortion can be provided safely and effectively using telemedicine. As summarized in the recent NAS, Safety and Quality of Abortion Care Report, studies have found that the safety and efficacy of medication abortion is not altered by its provision through telemedicine;[20] the provision of medication abortion through telemedicine increases the percentage of women choosing medication abortion, particularly in rural areas; and the provision of medication abortion through telemedicine increases the likelihood that women obtained an abortion earlier in pregnancy.[21]

IV. The Provision of Medication Abortion Using Telemedicine Significantly Benefits Kansan Women.

24. In Kansas, as is the case in most of the states in which I practice, individuals involved in abortion care are targeted for harassment or worse, making it difficult to hire local physicians to provide this necessary care. As a result, all Trust Women Wichita's physicians reside

[20] NAS, *Safety and Quality of Abortion Care* at 57-8 (citing Daniel Grossman and Kate Grindlay, *Safety of Medical Abortion Provided Through Telemedicine Compared With In Person*, 130(4) Obstetrics & Gynecology 778 (Oct. 2017)).
[21] NAS, *Safety and Quality of Abortion Care* at 58 (citing Dan Grossman, et al., *Changes in Service Delivery Patterns After Introducing Telemedicine Provision of Medical Abortion in Iowa*, 103(1) Am. J. Pub. Health 73 (Jan. 2013)).

out of state. To accommodate these physicians' schedules, the clinic typically has a single physician fly in every week, exchanging weeks, to provide abortion care on Thursdays and Fridays. As a result, prior to introducing telemedicine at the clinic, Trust Women Wichita could only offer abortion services on Thursdays and Fridays when a physician was at the clinic.

25. Telemedicine allows physicians to provide care remotely, eliminating the need to travel to the patients' location and thus expanding the number of physicians available to treat patients. At Trust Women Wichita, the use of telemedicine has enhanced access to abortion care by expanding the number of available providers and the times during which those providers may see patients. As a result, through telemedicine, patients at Trust Women Wichita may access out-of-state doctors who would otherwise be unable to provide care to them. Telemedicine allows Trust Women Wichita to provide care using these out-of-state doctors Monday through Saturday with expanded hours, subject to patients' needs and physicians' availability, such that patients can more easily fit the procedure into their schedules and access abortion sooner.

26. Expanding access to medication abortion using telemedicine can also lower many obstacles patients face when seeking abortion care. For many of my patients, including those in Kansas, it is difficult to visit an abortion clinic during normal business hours. This may be due to demanding and unpredictable work schedules, school, childcare, or other family obligations. These problems may be compounded if they are trying to keep their decision confidential. Some may be in abusive relationships or have controlling partners and face additional difficulties because they must conceal their logistical efforts, and the procedure itself, from their partners. Since medication abortion is generally only available to women up until 10 weeks LMP, all these difficulties can prevent some women from obtaining medication abortion because they will not be able to visit the clinic within the gestational range medication abortion is available. Trust Women

Wichita's ability to offer medication abortion appointments Monday through Saturday with expanded clinic hours helps to lower these hurdles, allowing women to seek care sooner.

27. While abortion is incredibly safe, the risks from abortion increase when the pregnancy is further along. Likewise, while medication abortion is very effective—only rarely requiring surgical follow-up—it is most effective and carries the lowest risk of needing surgical follow-up if done earlier in pregnancy. Thus, telemedicine, by making it easier for women to access medication abortion care earlier, further enhances the safety of medication abortion and lowers the risk that patients will need to undergo surgical follow-up, which these patients sought to avoid in the first place.

28. In addition to these scheduling hurdles, for many of Trust Women Wichita's patients, it is extremely difficult to pay for an abortion. Approximately 30% of the clinic's patients receive NAF or other funding assistance. To qualify for this funding, a patient must live at or below the federal poverty line. Further, Kansas law prohibits both public and private insurance coverage for abortion, and, therefore, patients must find the resources to pay for the procedure out-of-pocket.

29. In general, an abortion is less expensive if it is performed earlier in pregnancy. At Trust Women Wichita, the cost of a first trimester abortion, whether medication abortion or surgical, ranges from $600 to $750. The cost of an abortion at later gestations goes up considerably and can cost three, even four times as much as a first-trimester abortion. By making it easier for women to access care earlier, it makes the care women receive less of a financial burden.

30. Beyond these scheduling and financial obstacles, for many women—particularly those who live great distances from the clinic—it is extremely difficult to arrange transportation to their appointments at the clinic. In Kansas, some women, particularly those from western

Kansas, must travel 180 miles to reach the nearest abortion clinic.[22] At Trust Women Wichita, 12% of the clinic's patients live in western Kansas. Trust Women Wichita intends to use telemedicine to provide care to patients living in these areas without the need for travel to a clinic. For women living in remote parts of Kansas, the ability to access medication abortion via telemedicine could be life-changing, making the difference between accessing this necessary healthcare and carrying an unwanted pregnancy to term.

31. While Trust Women Wichita currently only uses telemedicine to provide care using physicians who are remote, the clinic intends to use telemedicine in the future to provide care to women living in remote areas such that travel to the clinic would be unnecessary.

32. For all the foregoing reasons, the use of telemedicine offers a safe and effective way of providing medication abortion and could expand access to safe and legal abortion in Kansas. By prohibiting the provision of medication abortion through telemedicine, the Challenged Laws provide no benefit to women's health—on the contrary, they harm women by unnecessarily restricting access to safe and legal abortion.

[22] Jonathan M. Bearkak, Kristen Lagasse Burke and Rachel K. Jones, *Disparities and Change over Time in Distance Women Would Need to Travel to Have an Abortion in the USA: A Spatial Analysis*, 2(11) The Lancet Pub. Health e493, e497 (Nov. 2017), https://www.thelancet.com/action/showPdf?pii=S2468-2667%2817%2930158-5.

Signed this 1 day of March 2019.

Colleen McNicholas, D.O., M.S.C.I., F.A.C.O.G.

KATHERINE ANN KNUTTER
Notary Public, State of Oklahoma
Commission # 16006778
My Commission Expires July 14, 2020

Exhibit 4

IN THE DISTRICT COURT OF
SHAWNEE COUNTY, KANSAS

2011 DEC -2 P 1:42

Hodes & Nauser, MDs, P.A.,
et al.,

Plaintiffs,

v.

Case No. 11 C 1298
Division No. 7

Robert Moser, M.D., in his official
Capacity as Secretary of the Kansas
Department of Health and Environment,
et al.,

Defendants.

Pursuant to K.S.A. Chapter 60

AGREED ORDER

The parties have agreed and jointly stipulated that the Temporary Restraining Order entered on November 10, 2011, shall remain in effect pending the Court's issuance of a final judgment in this matter. During the pendency of these proceedings, defendants shall not seek to enforce either the statutory Act or the Permanent Regulations promulgated by the Kansas Department of Health and Environment.

Therefore, upon this agreement and joint stipulation of the parties, the Court cancels the Temporary Injunction Hearing scheduled on December 6-7, 2011. The Court shall conduct a Status & Scheduling Conference beginning at 9:30 a.m. on December 6, 2011, or as soon thereafter as the matter may be heard.

IT IS SO ORDERED.

12/2/11
Date

Hon. Franklin R. Theis
District Court Judge