



THE DISTRICT COURT OF OKLAHOMA COUNTY
STATE OF OKLAHOMA

FILED IN DISTRICT COURT
OKLAHOMA COUNTY

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RICK WARREN
COURT CLERK

112

CASE NO. _____

CV - 2021 - 2072

OKLAHOMA CALL FOR REPRODUCTIVE JUSTICE, on behalf of itself and its members; TULSA WOMEN'S REPRODUCTIVE CLINIC, LLC, on behalf of itself, its physicians, its staff, and its patients; ALAN BRAID, M.D., on behalf of himself and his patients; COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, INC., on behalf of itself, its physicians, its staff, and its patients; and PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, on behalf of itself, its physicians, its staff, and its patients.

Plaintiffs,

v.

JOHN O'CONNOR, in his official capacity as Attorney General for the State of Oklahoma; DAVID PRATER, in his official capacity as District Attorney for Oklahoma County; STEVE KUNZWEILER, in his official capacity as District Attorney for Tulsa County; LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; KATIE TEMPLETON, in her official capacity as President of the Oklahoma State Board of Osteopathic Examiners; LANCE FRYE, in his official capacity as the Commissioner of the Oklahoma State Board of Health; and JUSTIN WILSON, in his official capacity as the President of the Oklahoma State Board of Pharmacy; as well as their employees, agents, and successors,

Defendants.

MEMORANDUM OF LAW IN SUPPORT OF
PLAINTIFFS' MOTION FOR A TEMPORARY INJUNCTION

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I. INTRODUCTION

In its 2021 session, the Oklahoma Legislature has run roughshod over decades of precedent protecting a person's right to choose to terminate a pregnancy. In a particularly draconian turn of Oklahoma's decades-long campaign against abortion providers and Oklahomans seeking abortion, the State has enacted five bills (collectively, the "Challenged Laws") restricting abortion in practically every conceivable way—including two outright bans on abortion and three extreme restrictions designed to dramatically limit access to care.

House Bill 1102 (the "Total Ban") bans abortion entirely by defining the provision of abortion as unprofessional conduct by physicians. House Bill 2441 (the "6-Week Ban") bans abortion at approximately 6 weeks as dated from a person's last menstrual period ("LMP") based on the detection of cardiac activity. House Bill 1904 (the "OB/GYN Requirement") arbitrarily bars many providers in Oklahoma from providing care because they happen to not be board-certified in obstetrics and gynecology but are board-certified in family medicine or other specialties. Senate Bill 778 and Senate Bill 779 (together, the "Medication Abortion Restrictions") set forth encyclopedic schemes of restrictions—many unrelated to medication abortion or, indeed, each other, and several of which have already been struck down by the Oklahoma Supreme Court or the United States Supreme Court.

None of the Challenged Laws serve a legitimate state interest; Oklahoma's transparent purpose is to eliminate abortion access. Oklahoma can have no legitimate interest in enacting the OB/GYN Requirement and the Medication Abortion Restrictions when it simultaneously bans abortion outright. The Challenged Laws violate the Oklahoma Constitution's Due Process Clause and its single subject rule and should be enjoined in full.

II. STATEMENT OF FACTS

A. Abortion Is Safe and Common

Abortion is one of the safest forms of medical care in the United States. Affidavit of Ushma Upadhyay, M.P.H, Ph.D. (Ex. 4) (“Upadhyay Aff.”) ¶¶ 19-26. Serious complications occur in fewer than one percent of abortions. *Id.* ¶ 20. One in four American women will obtain an abortion in their lifetime. *Id.* ¶ 36. Approximately 5,000 patients a year obtain abortions in Oklahoma. Affidavit of Alan Braid, M.D. (Ex. 2) (“Braid Aff.”) ¶ 14. There is no typical abortion patient—patients choose abortion for myriad personal and often complex reasons, including familial, medical, and financial concerns. Affidavit of Joshua Yap, M.D., M.P.H. (Ex. 3) (“Yap Aff.”) ¶ 8; Braid Aff. ¶ 24.

There are generally two methods of abortion—medication and procedural. Upadhyay Aff. ¶¶ 11-13. Medication Abortion is one of the safest medication regimens in medicine today. *Id.* ¶ 19. The most common form of medication abortion is a regimen of two prescription oral medications, mifepristone and misoprostol. *Id.* ¶ 12. Research shows that this regimen is comparable in safety to many common medications such as antibiotics, Advil, and Tylenol. *Id.* ¶ 28. Over time, the FDA has revised its original label for mifepristone to recommend lower dosages, longer availability, and removal of in-person follow-up requirements, reflecting the superior evidence-based protocols used by physicians. *Id.* ¶ 29. Medical evidence continues to accumulate demonstrating the safety and efficacy of the regimen; for example, some clinicians now follow the evidence-based practice of providing medication abortion through 77 days or 11 weeks LMP. *Id.* ¶¶ 29-31; Yap Aff. ¶¶ 52, 55. Procedural abortion is a straightforward procedure that involves the use of instruments or medications to gently dilate (open) the cervix and remove the contents of the uterus. Braid Aff. ¶ 17; Yap Aff. ¶ 51; Upadhyay Aff. ¶ 13.

Both procedural and medication abortion are similar or identical to care provided to

manage a patient's miscarriage. Yap Aff. ¶ 45; Affidavit of Joey Banks, M.D. (Ex. 5) ("Banks Aff.") ¶¶ 23-24. A wide range of clinicians provide abortion care in the United States, including family medicine doctors, obstetrician/gynecologists ("OB/GYNs"), and some advanced practice clinicians. *Id.* ¶ 16; Upadhyay Aff. ¶¶ 14, 23-25.

B. Plaintiffs

Oklahoma Call for Reproductive Justice ("OCRJ") is a 501(c)(4) nonprofit that advances reproductive justice and protects access to reproductive healthcare, including abortion, in Oklahoma. Affidavit of Priya Desai (Ex. 1) ("OCRJ Aff.") ¶ 1.

Dr. Alan Braid is a board-certified OB/GYN who owns Tulsa Women's Reproductive Clinic ("Tulsa Women's") and provides abortion care there. Braid Aff. ¶ 1.

Tulsa Women's, Comprehensive Health of Planned Parenthood Great Plains Inc. ("CHPPGP"), and Planned Parenthood of Arkansas & Eastern Oklahoma ("PPAEO") (collectively, the "Provider Plaintiffs") are licensed Oklahoma abortion facilities. *Id.* ¶ 8; Yap Aff. ¶ 7. Tulsa Women's provides medication abortion through 10 weeks LMP and procedural abortion through 18 weeks LMP. Braid Aff. ¶ 7. Six physicians provide abortion care at Tulsa Women's; three are board-certified family medicine doctors and three are board-certified OB/GYNs. *Id.* ¶ 12. Both CHPPGP and PPAEO provide medication abortion through 11 weeks LMP and procedural abortion through approximately 17 weeks LMP. Yap Aff. ¶ 6. CHPPGP operates a health center in Oklahoma City and employs four part-time physicians who each provide a few days per month—three are board-certified in family medicine, and the fourth is a board-certified OB/GYN. *Id.* ¶¶ 19, 41, 82. PPAEO operates a health center in Tulsa and employs one full-time physician who is board-certified in family medicine. *Id.* ¶¶ 4, 21, 38.

C. Legislative and Executive Efforts to Restrict Abortion in Oklahoma

For decades, Oklahoma has persistently attacked abortion access by enacting numerous

medically unjustified restrictions, many of which have been enjoined, including requirements that are very similar—if not identical—to ones being challenged in this case, such as mandatory ultrasounds, an admitting privileges requirement, and various restrictions on medication abortion.¹ Other restrictions, however, remain.²

D. The Harms of Being Delayed in Accessing or Denied Abortion Care

Pregnant people in Oklahoma must already overcome many obstacles to obtain abortions. Yap Aff. ¶¶ 14-15, 60, 80; Braid Aff. ¶¶ 23-24, 41; Upadhyay Aff. ¶¶ 38-45. This is particularly true for poor and low-income people who make up the majority of patients who seek abortion. Yap Aff. ¶ 10; Braid Aff. ¶¶ 23-24, 71; Upadhyay Aff. ¶¶ 37, 39, 44. Low-income people face difficulties taking time off work (and thus foregoing income), finding childcare, and paying for gas or other transportation costs. Yap Aff. ¶¶ 10, 14, 60; Braid Aff. ¶ 72; Upadhyay Aff. ¶ 39. Some patients also have to navigate threats to their safety due to intimate partner violence. Yap

¹ *S. Wind Women's Ctr. LLC v. Stitt*, 455 F. Supp. 3d 1219, 1232 (W.D. Okla. 2020), *appeal dismissed as moot*, 823 F. App'x 677 (10th Cir. 2020) (enjoining most of executive order banning abortions purportedly due to COVID-19); *Okla. Coal. for Reprod. Just. v. Cline* ("Cline IV"), 2019 OK 33, ¶ 43, 441 P.3d 1145, 1161 (permanently enjoining a law mandating an outdated protocol for providing medication abortion); *Burns v. Cline* ("Cline III"), 2016 OK 121, ¶ 19, 387 P.3d 348, 354 (permanently enjoining bill including an admitting-privileges requirement); *Burns v. Cline* ("Cline II"), 2016 OK 99, ¶ 19, 382 P.3d 1048, 1053 (permanently enjoining bill including amendments to minor consent for abortion); *Cline v. Okla. Coal. for Reprod. Justice* ("Cline I"), 2012 OK 102, ¶ 3, 292 P.3d 27, 27-28 (permanently enjoining law restricting access to medication abortion); *Nova Health Sys. v. Pruitt*, 2012 OK 103, 292 P.3d 28 (permanently enjoining mandatory ultrasound law); *Davis v. Edmondson*, No. CJ-2009-9154, 2010 WL 1734636 (Okla. Dist. Ct. Mar. 2, 2010) (permanently enjoining a 2009 statute imposing multiple abortion restrictions); *Nova Health Sys. v. Edmondson*, 2010 OK 21, ¶ 3, 233 P.3d 380 (permanently enjoining a 2008 statute imposing multiple abortion restrictions); *see also Tulsa Women's Reprod. Clinic, LLC v. Hunter*, No. CV-2019-2176 (Okla. Dist. Ct. Oct. 29, 2019) (preliminarily enjoining "medication abortion reversal" law).

² Oklahoma's administrative code outlines extensive requirements for abortion facilities relating to administration, staffing, clinical services, recordkeeping, and physical plants. O.A.C. §§ 310:600-1-1-310:600-13-3. No public facilities or hospitals may be used for abortions, and, with limited exceptions, no public employees may provide abortions. 63 O.S. § 1-741.1(A). All people seeking abortions are already subject to a 72-hour mandatory delay and biased counseling. 63 O.S. § 1-738.2. People who rely on Medicaid can obtain coverage for abortion only if the pregnancy is life-threatening or the result of rape or incest. 63 O.S. § 1-741.1(B); Pub. L. No. 116-260, 128 Stat. 409, §§ 506-07.

Aff. ¶ 80. Clinics are located in metropolitan areas so many patients must already travel significant distances to access care given that Oklahoma is a rural state, which also lacks meaningful public transportation. Yap Aff. ¶ 60; Upadhyay Aff. ¶ 39. All of these barriers are particularly significant for Black and Indigenous Oklahomans and other people of color who disproportionately experience poverty and barriers to healthcare. Yap Aff. ¶¶ 11-13, 80; OCJR Aff. ¶ 6.

Additionally, there is a shortage of providers in Oklahoma due to the stigma around abortion, the harassment that providers face, and state laws that make it harder to provide care, all of which combine to make it difficult to hire providers. Yap Aff. ¶¶ 22-28; Braid Aff. ¶¶ 52-56, 90, 96; Banks Aff. ¶¶ 27-29. When abortion access is reduced—whether due to logistical barriers or a reduction in providers forcing patients to travel greater distances and creating a backlog of appointments—people are delayed and forced to have abortions later in pregnancy. Upadhyay Aff. ¶¶ 38-40; Braid Aff. ¶¶ 39, 68, 70 n.16, 74-76, 91, 98; Yap Aff. ¶¶ 15-16, 33, 63-65, 82. Some people are denied care entirely and forced to carry unwanted pregnancies to term; and others may seek to terminate a pregnancy outside of the medical system. Upadhyay Aff. ¶¶ 38-40; Braid Aff. ¶¶ 41, 98; Yap Aff. ¶¶ 63, 80. Even small increases in logistical obstacles have dramatic effects on people's ability to access care. Upadhyay Aff. ¶ 38-39; Braid Aff. ¶¶ 70-76; Yap Aff. ¶ 16.

Abortion is a time-sensitive medical service. Abortion becomes more complex and expensive as pregnancy advances. Upadhyay Aff. ¶¶ 38-40. Although abortion remains safe, delays can impose increased medical risk because risk can increase as pregnancy advances. Upadhyay Aff. ¶ 41; Braid Aff. ¶¶ 39-40. Delays in accessing care can push people into later, more complex, and/or more expensive abortion procedures. Upadhyay Aff. ¶¶ 39-40; Braid Aff. ¶ 39, 68, 70 n.16, 74-76, 91, 98; Yap Aff. ¶¶ 16, 64-65. Delays in access may also exacerbate pregnancy-related medical conditions, such as hypertension. Upadhyay Aff. ¶ 41; Braid Aff. ¶ 40. Remaining

pregnant for longer than one wishes also causes tremendous stress, especially for sexual assault survivors, people experiencing intimate partner violence, or people who have received a fetal diagnosis. Upadhyay Aff. ¶¶ 39, 46; Yap Aff. ¶¶ 80, 84. Delays can also push patients beyond the point where abortion is available in Oklahoma. Braid Aff. ¶¶ 70 n.16, 74, 98; Yap Aff. ¶¶ 16, 63, 65.

Delays in accessing care can prevent people from being able to choose a medication abortion. Yap Aff. ¶¶ 16, 64; Braid Aff. ¶ 70 n.16, 75, 91, 98. Restrictions on access to medication abortion impose particular harms on Oklahomans, who overwhelmingly choose medication abortion over procedural abortion. Yap Aff. ¶ 54; Braid Aff. ¶¶ 19-20. Some patients prefer medication abortion because it gives them greater control over the process and timing; can be completed in the privacy of one's home; feels more natural or less invasive; and/or can be disguised as a miscarriage, which is an important factor for people who may wish to keep their decision private from others. Braid Aff. ¶¶ 65-66; Yap Aff. ¶ 53. Medication abortion is also safer than procedural abortion for some patients. Braid Aff. ¶ 66.

When people are denied the ability to choose an abortion, their lives are irrevocably altered—the State intrudes on their bodily autonomy and their ability to direct their own lives. OCRJ ¶ 20; Upadhyay Aff. ¶¶ 42-49. Denial of care also imposes substantial medical risk, as carrying a pregnancy to term is far riskier than abortion. Upadhyay Aff. ¶ 43. Braid Aff. ¶¶ 21-22; Banks Aff. ¶ 23. Further, research shows that people denied access to abortion experience worse psychological, physical, and financial health outcomes than people who were able to access care. Upadhyay Aff. ¶¶ 42-49. These women are more likely to experience poverty, health difficulties, and physical violence, as are their families. *Id.*

E. The Effects of the Challenged Laws

The Challenged Laws are the latest and most severe escalation of the State's attacks on the

right to abortion. Each either bans abortion outright or drastically reduces access to it.

1. The Total Ban

H.B. 1102 effectively bans abortion outright by making the “[p]erformance of an abortion” at any stage of pregnancy “unprofessional conduct” under Oklahoma’s physician licensing statutes. H.B. 1102 §§ 1(20) (amending 59 O.S. § 509), 2(14) (amending 59 O.S. § 637(14)). Violation of the Total Ban results in, at minimum, a one-year medical license suspension, *id.*, but may result in permanent licensure revocation and fines of up to \$5,000 per violation. 59 O.S. §§ 509.1, 637, 637.1. The only exception to the Total Ban is if an abortion is necessary to prevent a woman’s death or to “prevent substantial or irreversible physical impairment of the mother that substantially increases the risk of death,” excluding a risk of self-harm or suicide. H.B. 1102 §§ 1(20), 2(14). Cutting off abortion care in Oklahoma will immeasurably harm people seeking abortions in Oklahoma. *Supra* Part II(D).

2. The 6-Week Ban

The 6-Week Ban prohibits abortion after detection of cardiac activity, or a “heartbeat,”³ which occurs as early as approximately 6 weeks LMP—before many people even know they are pregnant and roughly *four months* prior to viability. H.B. 2441 §§ 1(A)-(B). A person who violates the ban is “guilty of homicide.” *Id.* § 1(D). The only exception mirrors the callously limited language used in the Total Ban. *Compare id.* § 1(A), (C) with *supra* Part II(E)(1).

According to Oklahoma State Department of Health data, from 2002-2018, approximately

³ Although the statute misleadingly uses the term “heartbeat,” embryonic or fetal cardiac activity is *not* a “heartbeat” in the lay sense, but electrical impulses present before development of the cardiovascular system. Braid Aff. ¶ 31.

60% of abortions in Oklahoma took place after 6 weeks LMP.⁴ Thus, the 6-Week Ban will prohibit a large majority of abortions performed in Oklahoma. Prior to and even after 6 weeks LMP, many individuals do not even know they are pregnant—particularly those who have irregular cycles, who have certain medical conditions, who have been using contraceptives, or who are breastfeeding. Braid Aff. ¶ 35; Yap Aff. ¶ 36. Even for those with highly regular 4-week cycles, 6 weeks LMP is a mere 2 weeks after they will have missed their period. Braid Aff. ¶¶ 36-37. The 6-Week Ban will thus limit them to *one to two weeks at most* to decide they want an abortion, arrange all of the necessary logistics, come up with the money, schedule the appointment, and wait 72 hours after receiving state-mandated information as required by Oklahoma law. Braid Aff. ¶ 37; Yap Aff. ¶ 36. This would become even more difficult if other onerous restrictions—such as the OB/GYN or ultrasound requirements, discussed *infra* Parts II(E)(3)-(4)—take effect. Braid Aff. ¶ 37; Yap Aff. ¶ 63. The 6-Week Ban will greatly harm Oklahomans and prevent many people from being able to obtain an abortion in Oklahoma. Braid Aff. ¶¶ 38, 42, 98; Yap Aff. ¶¶ 37, 82; OCRJ Aff. ¶ 13.

3. The OB/GYN Requirement

On top of banning abortion altogether, the Oklahoma legislature has also restricted abortion access by prohibiting physicians from providing abortions unless they are “board-certified in obstetrics and gynecology.” H.B. 1904 § 1 (amending 63 O.S. § 1-731(A)). As a primary sponsor stated, this bill is intended to “reduce the number of abortions.”⁵ Providing an abortion in violation of the OB/GYN Requirement is a felony, punishable by one to three years in prison. H.B. 1904 §

⁴ Okla. State Dept. of Health, *Detailed Induced Termination of Pregnancy Statistics*, https://www.health.state.ok.us/stats/Vital_Statistics/ITOP/Final/Statistics.shtml. The most recent Abortion Surveillance Report only reports abortions performed after 8 weeks LMP.

⁵ H.R., 58th Leg., 1st Reg. Sess., Day 18 (Okla. Mar. 2, 2021), Statement of Cynthia Roe.

1.

If permitted to take effect, six of the Provider Plaintiffs' ten physicians will be immediately disqualified from providing abortions in Oklahoma, shuttering almost all abortion services at the Planned Parenthood clinics and cutting the providers at Tulsa Women's by half. *Braid Aff.* ¶ 49; *Yap Aff.* ¶¶ 46, 48, 82. This will impose significant appointment delays, likely preventing at least some people from being able to obtain an abortion in Oklahoma at all. Even for those that can, the delays will nevertheless impose tremendous harm. *See supra* Part II(D).

There is no medical basis for the OB/GYN Requirement. The professional association for OB/GYNs, the American College of Obstetricians and Gynecologists, has publicly stated that such requirements are "medically unnecessary" and "designed to reduce access to abortion," as "clinicians in many medical specialties can provide safe abortion services." *Banks Aff.* ¶ 18; *see also Yap Aff.* ¶¶ 42-45. Training and experience, not specialty, determines competency to provide abortion care. *Banks Aff.* ¶¶ 14-20; *see also Yap Aff.* ¶¶ 39-40. Competence in abortion care is not a prerequisite for graduating from an OB/GYN residency program. *Banks Aff.* ¶ 17; *see also Yap Aff.* ¶ 43.

In particular, abortion is well within the broad scope of practice of family medicine physicians. *Banks Aff.* ¶¶ 22-26. Family medicine physicians can perform outpatient procedures more complex than abortion consistent with their training, such as colonoscopies, and they routinely prescribe medication of comparable risk, such as antibiotics. *Banks Aff.* ¶¶ 23-24. Moreover, family medicine physicians can provide miscarriage care, which largely calls for the same medicines and procedures as abortion. *Banks Aff.* ¶¶ 23-24; *Yap Aff.* ¶ 45.

4. S.B. 778

S.B. 778 includes myriad unrelated provisions that do nothing more than burden abortion access and abortion providers. For example, S.B. 778 includes a requirement that patients receive

an ultrasound at least 72 hours before a medication abortion, forcing patients to make an additional, medically unnecessary visit to a provider (even though a similar requirement has been held unconstitutional by the Oklahoma Supreme Court, *see infra* Part IV(A)(1)), S.B. 778 §§ 6(A)-(C), (E)(1), 8(A), (B)(6); *see also* Upadhyay Aff. ¶ 33; a mandate that providers file reports to be designated as “public records” and which must include identifying information about patients, abortion providers, and referring physicians and agencies, S.B. 778 §§ 8(B), (H); a bar on mailing abortion-inducing drugs, *id.* § 3; and a bar on the provision of medication abortion on any school or university facility or state grounds, *id.* § 5. Noncompliance with just one provision of the scheme results in an inability to provide medication abortion. *Id.* § 3.

The inaccessibility of medication abortion, which is extremely safe, less invasive than a procedural abortion, preferred by many patients, and safer for some patients, will significantly harm Oklahomans. *See supra* Parts II(A), (D). Compliance, on the other hand, will threaten the security and confidentiality of providers, referring providers, and patients and subject patients to medically unjustified requirements that threaten their ability to access medication abortion. Braid Aff. ¶¶ 94, 96; Yap Aff. ¶ 56; OCRJ Aff. ¶ 17. These requirements will irreparably harm Oklahomans seeking abortion. *See supra* Parts II(A), (D); Braid Aff. ¶¶ 68-82; Yap Aff. ¶¶ 79-80, 82, 84; OCRJ Aff. ¶ 19. The delays in care stemming from the 72-hour ultrasound requirement alone would greatly harm many people seeking abortions by pushing them past the cut-off for medication abortion. Braid Aff. ¶¶ 74-76; Yap Aff. ¶ 82; *supra* Part II(D).

5. S.B. 779

S.B. 779 creates a scheme entitled “Oklahoma Abortion-Inducing Drug Certification Program.” It delegates authority to four state agencies: two physician licensing boards; the pharmacy board, which must promulgate rules to certify physicians who provide abortion-inducing drugs and manufactures and distributors of abortion-inducing drugs, S.B. 779, §§ 4(A), 5(A), (C);

and the board of health, *id.* § 8(2)(d).

S.B. 779 includes myriad unrelated provisions, applying to different entities and involving different sanctions. For example, it includes: a limitation on providing medication abortion beyond 70 days or 10 weeks LMP, *id.* § 7(10)(b); Yap Aff. ¶¶ 55, 64; a requirement that doctors have hospital admitting privileges or contract with a physician who does (even though such requirements dramatically restrict access and have been held unconstitutional by both the U.S. and the Oklahoma Supreme Courts, *see infra* Part IV(A)(1)), S.B. 779 §§ 7(11), 8; licensing of manufacturers and distributors, which may chill such entities from supplying providers, S.B. 779 §§ 5(A)-(B), 6(2); tracking of medications, *id.* §§ 6(3), 7(14); record keeping and reporting obligations, resulting in the publication of provider, staff, and patient information, *id.* §§ 9(A)(7), 13(D); an enforcement scheme with heavy fines, *id.* § 12; and a system for making and receiving complaints, *id.* § 13. As with S.B. 778, noncompliance with just one provision of the scheme results in an inability to provide medication abortion, *e.g.*, *id.* § 12(A)(2), which will impose tremendous harm on patients, *see supra* Parts II(A), (D), (E)(4).

These requirements will irreparably harm Plaintiffs and their patients and members. The admitting privileges requirement alone will likely disqualify some of Provider Plaintiffs' physicians. Braid Aff. ¶¶ 88-89; Yap Aff. ¶¶ 73-76, 82. The reporting requirements threaten the security and confidentiality of providers, staff, and patients. Braid Aff. ¶¶ 94, 96; Yap Aff. ¶ 56; OCRJ Aff. ¶ 17. The 10-week restriction will bar anyone from obtaining medication abortion between 10 and 11 weeks LMP. Yap Aff. ¶¶ 55, 64.

III. LEGAL STANDARD

"The purpose of a temporary injunction is to preserve the status quo and prevent the perpetuation of a wrong or the doing of an act whereby the rights of the moving party may be

materially invaded, injured or endangered.” *Okla. Pub. Emps. Ass’n v. Okla. Mil. Dep’t*, 2014 OK 48, ¶ 15, 330 P.3d 497, 504 (citation omitted). “A temporary injunction protects a court’s ability to render a meaningful decision on merits of the controversy.” *Edwards v. Bd. of Cty. Comm’rs of Canadian Cty.*, 2015 OK 58, ¶ 10, 378 P.3d 54, 58 (citation omitted).

Temporary injunctive relief is warranted when it appears “the plaintiff is entitled to the relief demanded,” all or part of which consists of restricting the commission of an act that “would produce injury to the plaintiff.” 12 O.S. § 1382. Courts consider the following factors in determining whether to issue a temporary injunction: (1) the applicant’s likelihood of success on the merits; (2) irreparable harm to the party seeking relief if injunctive relief is denied; (3) whether the applicant’s threatened injury outweighs that of the opposing party; and (4) whether the injunction is in the public interest. *Dowell v. Pletcher*, 2013 OK 50, ¶ 7, 304 P.3d 457, 460 (citation omitted).

IV. LEGAL ARGUMENT

A. Plaintiffs Are Likely to Succeed on the Merits.

1. The Challenged Laws Likely Impose a Substantial Obstacle.

Under the Oklahoma Constitution, “[n]o person shall be deprived of life, liberty, or property, without due process of law.” Okla. Const. art. II, § 7. The Oklahoma Supreme Court has repeatedly recognized that this guarantee protects a person’s ability to choose to terminate a pregnancy prior to viability, in line with the federal constitution. *Cline IV*, 2019 OK ¶¶ 16, 25, 43, 441 P.3d at 1151, 1153-54, 1161 (citations omitted); *Cline III*, 2016 OK ¶ 8, 387 P.3d at 351-52. Restrictions on the right to abortion are subject to heightened scrutiny. *Cline IV*, 2019 OK ¶ 20, 441 P.3d at 1152. At a minimum, Oklahoma Courts apply the undue burden standard used by federal courts to determine the constitutionality of a state law that interferes with the right to

abortion.⁶ *Id.* Under that test, the State may not enact laws that interfere with the right to abortion by imposing an “undue burden” on a patient’s ability to exercise their right. *Id.* (citing *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292 (2016)). “A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.” *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 877 (1992).

If an abortion restriction has the effect of imposing a substantial obstacle, it is unconstitutional. *See Cline IV*, 2019 OK ¶ 20, 441 P.3d at 1152. An outright prohibition on abortion at any stage before viability constitutes the quintessential undue burden because it imposes an *insurmountable* obstacle. *See Casey*, 505 U.S. at 846. In evaluating whether a restriction short of a prohibition creates a substantial obstacle, a court must consider the “burdens a law imposes on termination access together with the benefits the law confers.” *Cline IV*, 2019 OK ¶ 26, 441 P.3d at 1154; *see also id.* ¶ 43, 441 P.3d at 1161. Where the burdens a law imposes exceed its benefits, they are undue, and thus unconstitutional. *Whole Woman’s Health*, 136 S. Ct. at 2300, 2309-10. Further, where the U.S. Supreme Court has already “spoken”—i.e., weighed the benefits and burdens imposed by a particular restriction—Oklahoma courts are “bound by its pronouncements.” *Cline III*, 2016 OK ¶¶ 5, 18-19, 387 P.3d at 351, 353-54.

The 6-Week Ban and the Total Ban: These laws are clearly unconstitutional because they outright prohibit previability abortions. *Casey*, 505 U.S. at 846, 870-71; *Roe v. Wade*, 410 U.S. 113, 154 (1973). As the U.S. Supreme Court concluded in *Roe v. Wade*, the right to abortion is centered on the ability to choose to terminate a pregnancy prior to viability—a prohibition strikes

⁶ In this motion, Plaintiffs focus on the federal undue burden standard. But, Plaintiffs expressly reserve and do not waive their argument that the Oklahoma Constitution has strong, independent protections for individual liberty, privacy, and health, which encompass the right to abortion.

at the heart of that right. *Id.* Moreover, every court to have evaluated a prohibition on abortion pegged to a specific gestational age prior to viability has so concluded.⁷

The OB/GYN Requirement: It is also well settled that the State may not enact provider qualifications that have “no effect on the quality of care the patient receives,” but would “cause[] a significant reduction in abortion providers, creating an onerous burden to women of child-bearing age.” *Cline III*, 2016 OK ¶¶ 13, 19, 387 P.3d at 353-54; *Whole Woman’s Health*, 136 S. Ct. at 2300, 2309-10; *June Med. Servs. L.L.C. v. Russo*, 140 S. Ct. 2103, 2133 (2020) (plurality opinion); *id.* at 2135 (Roberts, C.J., concurring in the judgment). But that is precisely what the OB/GYN Requirement does. Indeed, it imposes an undue burden for the same reasons as the admitting privileges requirements invalidated in *Cline III*, *Whole Woman’s Health*, and *June Medical Services*. The U.S. Supreme Court affirmed just last term that state abortion restrictions impose a substantial obstacle where, as here, they reduce the number of providers, resulting in “longer wait times, increased crowding, and increased health risk,” without medical justification. *June Med. Servs.* 140 S. Ct. at 2140-41; *see also supra* Parts II(D), (E)(3).

The Medication Abortion Restrictions: It is also well-established in Oklahoma that the State may not impose medically irrelevant restrictions on medication abortion. In 2012, the Oklahoma Supreme Court struck down House Bill 1970, which required providers to adhere to an

⁷ *See, e.g., Jackson Women’s Health Org. v. Dobbs*, 951 F.3d 246, 248 (5th Cir. 2020) (six-week ban); *MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768, 773 (8th Cir. 2015) (6-week ban), *cert. denied*, 136 S. Ct. 895 (2016); *Edwards v. Beck*, 786 F.3d 1113, 1117 (8th Cir. 2015) (12-week-ban), *cert. denied*, 577 U.S. 1102 (2016); *McCormack v. Herzog*, 788 F.3d 1017, 1029 (9th Cir. 2015) (equivalent of 22-week LMP ban); *Isaacson v. Horne*, 716 F.3d 1213, 1217 (9th Cir. 2013) (20-week ban), *cert. denied*, 571 U.S. 1127 (2014); *Jane L. v. Bangerter*, 102 F.3d 1112, 1114, 1117-18 (10th Cir. 1996) (equivalent of 22-week LMP ban); *Sojourner T. v. Edwards*, 974 F.2d 27, 31 (5th Cir. 1992), *cert. denied*, 507 U.S. 972 (1993) (ban at all gestational ages); *Guam Soc’y of Obstetricians & Gynecologists v. Ada*, 962 F.2d 1366, 1368-69 (9th Cir. 1992) (ban at all gestational ages), *cert. denied*, 506 U.S. 1011 (1992); *SisterSong Women of Color Reprod. Just. Collective v. Kemp*, 410 F. Supp. 3d 1327, 1312 (N.D. Ga. 2020) (six-week ban), *appeal filed*, No. 20-13024 (11th Cir. Aug. 11, 2020).

outdated FDA label for medication abortion, thereby prohibiting providers from using a safer and more effective evidence-based protocol. *Cline I*, 2012 OK ¶ 2, 292 P.3d at 27-28.⁸ In 2019, the Oklahoma Supreme Court struck down House Bill 2684, which similarly imposed restrictions on access to medication abortion based on the outdated FDA label. *Cline IV*, 2019 OK ¶ 9, 441 P.3d at 1150.

Since 2019, it has only become clearer that medication abortion is exceedingly safe and that restrictions like H.B. 1970 and H.B. 2284 have no medical basis. *See supra* Part II(A). Yet, the Medication Abortion Restrictions in some ways *exceed* the burdens imposed by those laws the Oklahoma Supreme Court has already held to be unconstitutional. First, the Medication Abortion Restrictions mirror H.B. 1907 and H.B. 2264 in dictating the “usage” of medication abortion, the “timing” of care, and the number of “doctor’s office visits.” *See Cline IV*, 2019 OK ¶¶ 28-31, 441 P.3d at 1155-58. Second, the Medication Abortion Restrictions reenact significantly burdensome laws that the Oklahoma Supreme Court has already struck down as medically unjustified with respect to *all* abortion care (both medication and procedural), including a mandatory ultrasound at least 72 hours prior to an abortion, forcing patients to make an additional, medically unnecessary trip to a provider (S.B. 778), which is far more burdensome than the ultrasound requirement already invalidated in *Nova Health Sys.*, 2012 OK ¶ 1, 292 P.3d 28; and a medically unnecessary admitting privileges requirement which threatens to dramatically reduce the number of providers (S.B. 779), similar to that invalidated in *Cline III*, 2016 OK ¶ 17, 387 P.3d at 353; *see also* Upadhyay Aff. ¶¶ 8, 34.

⁸ The State appealed and the United States Supreme Court granted certiorari pending the Oklahoma Supreme Court’s answer of certified questions. *Cline v. Okla. Coal. for Reprod. Just.*, 2013 OK 93, ¶ 1, 313 P.3d 253, 255. After the Oklahoma Supreme Court answered these questions, the petition was dismissed as improvidently granted, leaving the decision intact.

As noted above, *see supra* Parts II(E)(4)-(5), the ultrasound and admitting privileges requirements alone will impose substantial delays on access to care and dramatically curtail access to medication abortion in Oklahoma. These delays and obstacles will compound the existing challenges faced by most Oklahomans seeking abortion care; specifically, “[t]raveling from rural areas might require a long journey or a two night stay away from home to access care, which increases costs for low-income patients, childcare, and time off from work and increases the chance that something might occur while traveling, making the procedure uncomfortable and more difficult to manage.” *Cline IV*, 2016 OK ¶ 34, 441 P.3d at 1158. Access to medication abortion is crucial in Oklahoma as the vast majority of Oklahoma patients choose medication abortion, and many do so “for privacy reasons; because it feels natural; because of past trauma; or because it is specifically medically indicated.” *Id.* ¶ 31, 441 P.3d at 1156; *Yap Aff.* ¶ 53; *Braid Aff.* ¶¶ 19-20, 65-66.

2. The Medication Abortion Restrictions Likely Violate the Single Subject Rule.

S.B. 778 and S.B. 779 include 30 new sections of law and over 300 subsections prescribing medically unnecessary restrictions on medication abortion that are largely unrelated to medication abortion or each other. As a result, the Medication Abortion Restrictions violate the Oklahoma Constitution’s single subject rule, which requires that, “[e]very act of the Legislature shall embrace but one subject, which shall be clearly expressed in its title.” Okla. Const. art. V, § 57. The rule has two purposes, neither of which a statute can offend: (1) “to ensure that the legislators . . . of Oklahoma are adequately notified of the potential effect of the legislation” and (2) “to prevent ‘logrolling’, the practice of assuring the passage of a law by creating one choice in which a legislator . . . is forced to assent to an unfavorable provision to secure passage of a favorable one, or conversely, forced to vote against a favorable provision to ensure that an unfavorable provision

is not enacted.” *See, e.g., Cline III*, 2016 OK ¶ 21, 387 P.3d at 354 (footnote omitted).

To be constitutional under the single subject rule, a statute’s various provisions must all be “germane, relative, and cognate to a readily apparent common theme or purpose.” *See Hunsucker v. Fallin*, 2017 OK 100, ¶ 31, 408 P.3d 599, 610 (footnote omitted); *Cline III*, 2016 OK ¶ 27, 387 P.3d at 355 (footnote omitted). A statute will not satisfy this test merely because one can “articulate some rational connection between similar or related provisions.” *Cline II*, 2016 OK ¶ 11, 382 P.3d at 1051.

The Oklahoma Supreme Court has struck down bills with fewer unrelated requirements than those in S.B. 778 and S.B. 779, and it has made clear that such bills cannot survive constitutional scrutiny simply “because each sub-part relates in some way to abortion.” *Cline III*, 2016 OK ¶ 26, 387 P.3d at 355; *see also Cline II*, 2016 OK ¶ 18, 382 P.3d at 1053 (“Although each section relates in some way to abortion, the broad sweep of each section does not cure the single subject defects in this bill.”).

Cline III is particularly instructive. There, the Oklahoma Supreme Court invalidated a statute that was “comprised of twelve unrelated provisions subjecting abortion providers to added regulation.” 2016 OK ¶¶ 20-30, 387 P.3d at 354–56. These provisions were no more disparate than those of S.B. 778 and S.B. 779, spanning “(1) supplies and equipment, (2) training of physician’s assistant and volunteers, (3) medical screening and evaluation, [] (4) abortion procedure and post-procedure follow-up care, (5) [] record keeping and reporting requirements . . . , [and] (6) . . . hospital admitting privileges,” *id.* ¶¶ 25, 28, 387 P.3d at 355–56, as well as “significant penalties for simple violations,” *id.* ¶ 23, 387 P.3d at 354.

As in *Cline III*, S.B. 778 and S.B. 779 span numerous “unrelated provisions subjecting abortion providers to added regulation.” *Id.* S.B. 778 includes 14 new sections of law with over

100 subsections covering numerous unrelated components as described *supra* Part II(E)(4), including reporting requirements and mandatory ultrasounds for medication abortion patients. S.B. 779 is comprised of over 16 new sections of law with nearly 200 subsections applying myriad unrelated requirements to multiple different entities (physicians, pharmaceutical manufacturers, and distributors), as described *supra* Part II(E)(5), and amending three different statutes. The bills all include significant criminal and civil penalties and permit private rights of action. *See supra* Parts II(E)(4)-(5).

The Medication Abortion Restrictions also impermissibly delegate authority to multiple agencies in violation of the single subject rule. In *Cline II*, the Oklahoma Supreme Court struck down a statute that, among other things, set forth both civil and criminal penalties for a violation of any existing regulation relating to abortion. 2016 OK ¶¶ 10, 13, 382 P.3d at 1051-52. The Court found that the law violated the single subject rule by including “directives to different state entities for different purposes” as it imposed civil, criminal, and licensure penalties, delegating “authority to three different state agencies.” *Id.* ¶ 13, 382 P.3d at 1052. The same is true here.

By logrolling numerous unrelated subjects into two expansive bills, delegating authority to multiple state agencies, and reenacting provisions already struck down by the courts, the Medication Abortion Restrictions present the “constitutionally prohibited all-or-nothing choice” the single subject rule was designed to prevent. *Id.* ¶ 18, 382 P.3d at 1053.

3. The Challenged Laws Were Enacted with an Improper Purpose.

The Challenged Laws were enacted for the improper purpose of reducing or eliminating abortion access in Oklahoma and are thus unconstitutional. *Whole Woman’s Health*, 136 S. Ct. at 2229 (citing *Casey*, 505 U.S. at 878).

“Legislative purpose to accomplish a constitutionally forbidden result may be found when that purpose was the predominant factor motivating the legislature’s decision.” *Jane L.*, 102 F.3d

at 1116 (internal citations and quotation marks omitted). A court must look at the totality of the circumstances, including “[t]he historical background” of the challenged action and the “legislative or administrative history.” *Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 267-68 (1977); *see also Jane L.*, 102 F.3d at 1116-17. Such an inquiry should also examine the potential effect of the challenged law, because “the effect of a law in its real operation is strong evidence of its object.” *Church of Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 535 (1993).

Laws that are merely “vehicle[s] by which to challenge *Roe*” have an improper purpose. *Jane L.*, 102 F.3d at 1116-17. The Total Ban and the 6-Week Ban are unquestionably such vehicles. The effect of these bans alone thus establishes an improper purpose.⁹ The primary sponsor of the OB/GYN Requirement affirmed that the bill was intended to limit abortions. *See supra* Part II(E)(3). Similarly, in the course of debate on S.B. 778 and S.B. 779, a co-author of the bills admitted he did not even know if any physicians were consulted in the drafting process, but that the restrictions were supported by anti-abortion organizations.¹⁰

That the Challenged Laws are so clearly at odds with controlling precedent and regulate abortion in a “manner specifically and repeatedly condemned by the Court evince[] an intent to prevent a woman from exercising her right to choose an abortion.” *Jane L.*, 102 F.3d at 1117. The effect of the Challenged Laws, when viewed with the candid legislative history, shows that their purpose is to systematically dismantle abortion access in Oklahoma.

⁹ Sponsors also admitted this. *See* Senate Session, 58th Leg., 1st Reg. Sess., Day 43, Statements of Sen. Julie Daniels (describing the Total Ban repeatedly as an effort to “limit abortions”), Statement of Sen. Shane Jett (stating in debate on the Total Ban, “let’s make [abortion] hard to do”); Statement of Sen. Jake Merrick (applauding the 6-Week Ban for “its attempt to slow and end abortion in Oklahoma”).

¹⁰ House Session, 58th Leg., 1st Reg. Sess., Day 45, 65, Statements of Rep. Mark Lepak.

B. Oklahomans Seeking Abortion Care Will Suffer Irreparable Harm.

Harm is “irreparable” when it “is incapable of being fully compensated by money damages,” or where the measure of damages is too “speculative” to calculate. *Edwards v. Bd. of Cty. Comm’rs of Canadian Cty.*, 2015 OK 58, ¶ 29, 378 P.3d 54, 63. Deprivation of fundamental constitutional rights is *per se* irreparable harm. *See Elrod v. Burns*, 427 U.S. 347, 373 (1976). Because the Challenged Laws suffer from numerous constitutional defects, they will unquestionably cause irreparable harm to Oklahomans seeking abortion care. As described above, *see e.g., supra* Parts II(D)-(E), the Challenged Laws will cause delays in and create barriers to access and deny people some people abortions entirely.

C. The Balance of Equities Weighs in Plaintiffs’ Favor and a Temporary Injunction Would Serve the Public Interest.

The public interest is always served by protecting the constitutional liberties of Oklahomans. *See e.g., Am. Civil Liberties Union v. Johnson*, 194 F.3d 1149, 1163 (10th Cir. 1999). In contrast, Defendants would not be harmed. A temporary injunction would preserve the status quo and allow the Court to consider the constitutionality of the Challenged Laws. *Okla. Pub. Emps. Ass’n*, 2014 OK ¶ 15, 330 P.3d at 504. Moreover, the equities must weigh strongly in Plaintiffs’ favor where, as here, the Court has struck down similar or identical restrictions as unconstitutional.

V. CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that this Court issue a temporary injunction preventing enforcement of the Challenged Laws pending final resolution of Plaintiffs’ claims or further order of the Court, and further request that bond be waived.

Dated: September 2, 2021

Respectfully Submitted,



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CERTIFICATE OF SERVICE

The undersigned hereby certifies that on this 2nd day of September, 2021, a true and correct copy of the foregoing was served via hand delivery to the following:

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EXHIBIT 1

**IN THE DISTRICT COURT OF OKLAHOMA COUNTY
STATE OF OKLAHOMA**

OKLAHOMA CALL FOR REPRODUCTIVE JUSTICE, on behalf of itself and its members; TULSA WOMEN'S REPRODUCTIVE CLINIC, LLC, on behalf of itself, its physicians, its staff, and its patients; ALAN BRAID, M.D., on behalf of himself and his patients; COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, INC., on behalf of itself, its physicians, its staff, and its patients; and PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, on behalf of itself, its physicians, its staff, and its patients,

Plaintiffs,

v.

JOHN O'CONNOR, in his official capacity as Attorney General for the State of Oklahoma; DAVID PRATER, in his official capacity as District Attorney for Oklahoma County; STEVE KUNZWEILER, in his official capacity as District Attorney for Tulsa County; LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; KATIE TEMPLETON, in her official capacity as President of the Oklahoma State Board of Osteopathic Examiners; LANCE FRYE, in his official capacity as the Commissioner of the Oklahoma State Board of Health; and JUSTIN WILSON, in his official capacity as the President of the Oklahoma State Board of Pharmacy; as well as their employees, agents, and successors,

Defendants.

CASE NO. _____

**AFFIDAVIT OF PRIYA DESAI IN SUPPORT OF PLAINTIFFS' MOTION FOR
TEMPORARY INJUNCTION**

Priya Desai declares and states the following:

1. I am a Board Member of Oklahoma Call for Reproductive Justice (“OCRJ”), a Plaintiff in this case. OCRJ is a 501(c)(4) nonprofit founded in 2010 to advance reproductive justice and protect access to reproductive healthcare, including abortion, in Oklahoma. OCRJ is exclusively dedicated to this cause. I have been involved with OCRJ since its founding and served as a Co-Chair of OCRJ from August 2016 to August 2020.

2. Oklahoma has a long history of encroaching on reproductive freedom. In 2010, the Oklahoma Legislature enacted a number of bills restricting abortion. That slate of bills included an ultrasound requirement mandating that a physician perform an ultrasound at least one hour before a procedure, similar to a component of one of the bills challenged in this case. Activists came together at the state capitol to protest what was then an unprecedented attack on reproductive freedom. OCRJ emerged out of this protest.

3. We are an all-volunteer organization with an executive board and two Co-Chairs. OCRJ is funded primarily by donations, although we occasionally apply for grants.

4. OCRJ’s membership includes Oklahomans of reproductive age who may need to terminate a pregnancy in Oklahoma in the future. These Oklahomans pay taxes to the State. Oklahomans of reproductive age include cis women but also transgender men, gender-nonbinary individuals, and gender-diverse individuals who may also become pregnant and seek abortion services.

5. Unfortunately, since 2010, the State has only become more emboldened in its assault on reproductive healthcare. I understand that the five bills challenged in this lawsuit impose a tremendous number of restrictions on abortion, and one law essentially bars access to abortion in Oklahoma entirely. OCRJ’s mission requires that we combat these restrictions to

protect the reproductive freedoms of the Oklahomans across the state that we represent—people who need access to abortion care and support the ability of others to access abortion.

Reproductive Justice in Oklahoma

6. OCRJ's mission is to promote reproductive justice in Oklahoma through education, empowerment, and advocacy. Reproductive justice is a framework developed by Black women to reflect the many intersecting ways people of color face challenges in forming their families. Reproductive justice includes not just access to abortion, but also:

- the ability of Oklahomans to decide if and when they will have a baby and the conditions under which they will give birth;
- the ability to parent the children they already have with the necessary social supports in safe environments and healthy communities—supports including good schools and healthcare and other elements necessary for bright futures, regardless of immigration status, and without fear of violence from individuals or the government;
- and, if they decide they will not have a baby, their ability to prevent or end a pregnancy.

Black and Indigenous Oklahomans and other Oklahomans of color face heightened challenges across this spectrum of reproductive choices. These same communities have experienced oppression for generations, dating back to horrific race- and gender-based violence. And, today, these same communities disproportionately experience poverty and lack of access to healthcare, education, and other services.

OCRJ's Work in Oklahoma and Its Mission

7. OCRJ advances reproductive justice in many ways. We advocate for or against bills in the legislature—we lobby against bills like the laws challenged in this case, but we have also supported the few bills that help pregnant people, including the legislation that barred shackling of pregnant incarcerated patients during labor. Prior to the pandemic, we hosted lobby days, during which we organized supporters to lobby members of the legislature. We have also rapidly deployed volunteers when we think there is an emergency threat in the legislature. We hold events for our legislative champions. When we can, we speak to the media in order to educate Oklahomans about legislation and the potential impact of such legislation on Oklahomans' access to reproductive healthcare.

8. We also provide education in the community and communicate directly with Oklahomans. We speak about our issues at community events. People follow our social media accounts where we share information about our advocacy and mission. We send out “Action Alerts” to mobilize people for advocacy opportunities. We participate in conferences, including by presenting on panels. We also publish a zine, *How to Get an Abortion in Oklahoma*, which is updated regularly and provides information to Oklahomans who need to navigate the many overlapping laws restricting abortion in the State. Since many in Oklahoma do not have access to a computer or the internet, we do our best to print copies of our zine and place them in libraries, facilities for domestic violence survivors, and any other community partner that is willing to have them. We have found that this is one of our most essential services given that there is a lot of confusion caused by the legislature's continued attacks on abortion. We often find that some Oklahomans believe that abortion is currently illegal in the State. Further, quality sex education is extremely poor if not entirely absent in many parts of the State. It is key that we provide non-judgmental information about abortion and how to access it given these realities.

9. It is particularly important for us to disrupt the stigma attached to abortion, abortion providers, and patients. For example, we joined together with faith leaders for a campaign called Faith & Abortion, through which we challenged the idea that abortion is immoral or inconsistent with all faiths. We also held a campaign called Abortion is an Act of Love where we highlighted compassion for ourselves and our communities in making decisions around reproductive healthcare.

10. Our supporters are diverse in their party affiliation, economic background, and lived experience, but all believe that pregnant Oklahomans deserve the ability to make decisions about their healthcare in line with their own values and intentions.

Impact of the Challenged Laws

11. The Challenged Laws will frustrate our mission and prevent us from advancing reproductive justice for all Oklahomans. As an advocacy organization, we cannot imagine all of the ways that these laws will impact providers and patients should even one go into effect, but we understand that if the laws are not blocked, they will essentially bar abortion care in the state entirely. Each law alone would dramatically harm access to abortion.

12. We understand that H.B. 1102 bans abortion entirely by declaring that providing abortion—constitutionally-protected healthcare—is unprofessional conduct by physicians requiring, at a minimum, suspension of licensure for one year. If abortions were entirely unavailable, every patient in Oklahoma would have to forego abortion and carry an unwanted pregnancy to term or, if they are able, travel long distances out of state to get care.

13. We understand that H.B. 2441 bans abortion at approximately six weeks in pregnancy, and that generally only a minority of patients know they are pregnant and are able to

receive care prior to that point in pregnancy. This would bar a large percentage of patients from receiving care in Oklahoma.

14. We understand that H.B. 1904 will significantly reduce the number of abortion providers in the state by barring highly skilled and competent physicians, including family medicine doctors, from providing abortions because they are not board-certified OB/GYNs. A large reduction in the number of physicians providing care in the state would have dramatic effects on access given how few providers there are in the state.

15. We understand that S.B. 778 imposes a severely burdensome, medically unnecessary scheme solely on doctors providing medication abortion. This scheme's many requirements even include an ultrasound requirement just for medication abortion (which must be obtained at least 72 hours in advance)—a requirement even more draconian than a similar ultrasound requirement that the Oklahoma Supreme Court declared unconstitutional.¹ For patients who do not get an ultrasound elsewhere, they must make two trips to the clinic, which would maximize the delays and barriers they face.

16. We understand that S.B. 779 requires various agencies to impose an equally intricate system of requirements for manufacturers, distributors, and providers of medication abortion. As just one example of this law's many provisions, the bill includes a requirement that providers of medication abortion have admitting privileges or contract with a physician who does. This component is similar to the admitting privileges requirement deemed unconstitutional by both the Oklahoma Supreme Court and the United States Supreme Court.²

¹ *Nova Health Sys. v. Pruitt*, 2012 OK 103, 292 P.3d 28.

² *Burns v. Cline*, 2016 OK 121, 387 P.3d 348; *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016); *June Med. Servs. L. L. C. v. Russo*, 140 S. Ct. 2103 (2020).

17. We also understand that both medication abortion bills have components that risk patient and provider privacy. S.B. 778 designates individual patient reports “public records.” S.B. 778 § 8(H). Although S.B. 778 includes a vague disclaimer prohibiting the publication of “information or identifiers that would make it possible to identify, in any manner or under any circumstances, a woman who has obtained or seeks to obtain a chemical abortion,” S.B. 778 § 8(C), this is a significant departure from existing law, which only publishes aggregated reports and has never made individual patient records “public records.” S.B. 779 requires reporting annually of a “list of staff attending patients including licensing numbers and evidence of other qualifications.” S.B. 779 § 9(A). Given the stigma and harassment faced by patients and providers, including the concerted efforts of anti-abortion activists to “out” abortion patients, OCRJ is very concerned that these requirements will risk patients’ and providers’ confidentiality and threaten their security.

18. OCRJ has served as a Plaintiff in two cases challenging other bills that regulated the manner and regimen of medication abortion—both bills were declared unconstitutional by the Oklahoma Supreme Court.³

19. Given the challenges that abortion patients face in the State—stigma, logistical barriers, societal and economic barriers, the COVID-19 pandemic—each of these laws would have a tremendous impact on Oklahomans.

20. The Challenged Laws will delay and deny access to abortion, which is essential to pregnant Oklahomans’ ability to direct their own lives and form healthy families consistent with their values. The Challenged Laws are thus directly contrary to our purpose and mission.

³ *Oklahoma Coal. for Reprod. Just. v. Cline*, 2019 OK 33, 441 P.3d 1145; *Oklahoma Coal. for Reprod. Just. v. Cline*, 2012 OK 102, 292 P.3d 27.

21. During this most recent legislative session, OCRJ marshalled its limited resources to combat the bills challenged in this case. We tracked the bills. Working with our coalition partners, we advocated against the bills. We lobbied legislators, and, for the first time, were able to persuade a member to read stories from abortion patients on the House floor. Even after hearing these stories from patients about how essential abortion was to their ability to determine the course of their health, lives, and families, the legislature passed the bills along with a “Trigger Ban,” which bans abortion outright should *Roe v. Wade* be reversed by the Supreme Court. Since the bills passed, we have been speaking out about these bills and how they are each unjustified by any legitimate concerns about women’s health, but rather motivated by a desire to ban abortion and burden abortion patients and providers.

22. Should these bills go into effect, we will do our best to continue to support Oklahomans who need access to abortion, but these bills will severely limit, if not outright prohibit, the availability of abortion care in the state. Our educational efforts will likely have to shift from educating people on how to obtain an abortion in Oklahoma⁴ to how to access abortion care outside of Oklahoma. Because traveling out of state will be incredibly difficult, if not impossible, for many people, we will likely try to redirect our limited resources to help patients financially as they find ways to obtain care out of state. But these bills will destroy all that we have sought to protect.

23. When a patient is denied an abortion, their life is irrevocably altered—the State forces them to remain pregnant against their will and thereby trespasses on their bodily autonomy and intentions for their own life. This should not be.

⁴ *Supra* ¶ 8.

24. We understand that many places in this country are experiencing similar onslaughts on abortion care. To this we say: Oklahoma should be a state that zealously guards the individual liberty of all. We hope that a court of this State will step in to preserve this liberty.

DATED: August 31, 2021

Priya Desai
Priya Desai

NOTARY Sarah Powers

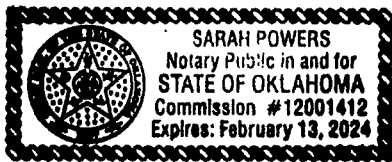


EXHIBIT 2

**IN THE DISTRICT COURT OF OKLAHOMA COUNTY
STATE OF OKLAHOMA**

OKLAHOMA CALL FOR REPRODUCTIVE JUSTICE, on behalf of itself and its members; TULSA WOMEN'S REPRODUCTIVE CLINIC, LLC, on behalf of itself, its physicians, its staff, and its patients; ALAN BRAID, M.D., on behalf of himself and his patients; COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, INC., on behalf of itself, its physicians, its staff, and its patients; and PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, on behalf of itself, its physicians, its staff, and its patients,

Plaintiffs,

v.

JOHN O'CONNOR, in his official capacity as Attorney General for the State of Oklahoma; DAVID PRATER, in his official capacity as District Attorney for Oklahoma County; STEVE KUNZWEILER, in his official capacity as District Attorney for Tulsa County; LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; KATIE TEMPLETON, in her official capacity as President of the Oklahoma State Board of Osteopathic Examiners; LANCE FRYE, in his official capacity as the Commissioner of the Oklahoma State Board of Health; and JUSTIN WILSON, in his official capacity as the President of the Oklahoma State Board of Pharmacy; as well as their employees, agents, and successors,

Defendants.

CASE NO. _____

**AFFIDAVIT OF ALAN BRAID, M.D. IN SUPPORT OF
PLAINTIFFS' MOTION FOR TEMPORARY INJUNCTION**

Dr. Alan Braid declares and states the following:

I. Background

1. I am a board-certified obstetrician and gynecologist (“OB/GYN”), licensed to practice medicine in the states of Oklahoma and Texas. I am also the principal owner of Tulsa Women’s Reproductive Clinic, LLC, an Oklahoma corporation, which operates a reproductive healthcare facility in Tulsa (the “Clinic”). I provide abortion services at the Clinic.

2. I have been providing reproductive healthcare, including abortion care, since 1978. I currently practice medicine in Texas and Oklahoma. I have been providing reproductive healthcare, including abortion care, in Oklahoma since September 2018 after I purchased the Clinic. I also provide abortion care at Alamo City Surgery Center PLLC d/b/a Alamo Women’s Reproductive Services in San Antonio, Texas (“Alamo”). I am the co-owner of Houston Women’s Reproductive Services in Houston, but I do not provide services there.

3. I graduated from the University of Texas Health Science Center at San Antonio with an M.D. in 1972. I completed my internship in obstetrics and gynecology at Bexar County Hospital District in 1973. I completed my residency in obstetrics and gynecology in 1976. I have extensive experience and training in reproductive healthcare, covering the full spectrum of care from obstetrics to abortion.

4. I am a Diplomate of the American Board of Obstetrics and Gynecology.¹ My full credentials are listed in my CV, which is attached hereto as Exhibit A.

¹ The American Board of Obstetrics and Gynecology (ABOG) board certifies obstetricians and gynecologists (OB/GYNS) in the U.S. and Canada. ABOG certifies as Diplomates those who obtain and maintain board certification. ABOG’s certification standards are distinct from state licensure requirements and board certification and maintenance are voluntary. *See* Am. Bd. of Obstetrics & Gynecology, *Definition of an Obstetrician and Gynecologist*, <https://www.abog.org/about-abog/policies/definition-of-an-obstetrician-and-gynecologist> (last visited August 29, 2021).

5. I have read Oklahoma House Bills No. 1102 (“H.B. 1102”), No. 2441 (“H.B. 2441”), and No. 1904 (“H.B. 1904”) and Oklahoma Senate Bills No. 778 (“S.B. 778”) and No. 779 (“S.B. 779”), which were enacted during the 2021 Oklahoma legislative session. I submit this declaration in support of Plaintiffs’ Motion for Temporary Injunction.

6. The facts and opinions I state here are based on my education and training, my nearly 5 decades of experience as a practicing physician specializing in the fields of obstetrics and gynecology, my review of the Clinic’s business records, information obtained in the course of my duties at the Clinic, my review of scientific and medical literature and data, and personal knowledge that I have acquired through my work at and ownership and management of the Clinic.

II. The Clinic

7. The Clinic is a medical practice in Tulsa, Oklahoma, which provides high-quality reproductive healthcare, including abortion services, to patients primarily from Oklahoma, as well as to patients who travel to Oklahoma from Texas, Missouri, Kansas, and Arkansas. Approximately five days per week, the Clinic provides medication abortion to patients up to 70 days or 10 weeks of pregnancy, as measured from the first day of a woman’s last menstrual period (“LMP”). The Clinic also provides procedural abortion to patients up to 17 weeks and 6 days LMP approximately three days per week, typically on Wednesdays through Fridays. The Clinic also provides some non-abortion services, including the management of a miscarriage via medication or procedure, which is largely identical to abortion care, as well as hormonal oral and injection contraception.

8. The Clinic is certified by the National Abortion Federation (NAF) and licensed as an abortion facility by the Oklahoma State Board of Health. It also has Clinical Laboratory

Improvement Amendments (CLIA) certification. The Clinic's physicians and staff strive to provide only the best, evidence-based medical care to our patients.

9. I purchased the Clinic in 2018 and assumed clinic operations in August 2018; it had previously been in operation under a different name for over forty years. The previous owner was getting ready to retire, and I purchased the Clinic to ensure the Clinic's patients would continue to have access to abortion care.

10. The Clinic is one of only four facilities providing abortion in Oklahoma. There is one other clinic in Tulsa. Two clinics are located in Oklahoma City.

11. I have been traveling to Oklahoma to provide abortion care at the Clinic since September 2018. As the Clinic's principal owner, I handle personnel matters and the Clinic's business affairs. I also work with the Clinic's Medical Director to set policies and procedures for all medical care at the Clinic, including but not limited to patient education and counseling for medication abortions, in-clinic medication abortion care, and post-medication abortion follow up appointments and complications management. If any questions arise at the Clinic regarding a medical procedure, the Clinic's Medical Director and I resolve them together.

12. Five other physicians provide abortion care at the Clinic on a part-time basis. I and two other physicians—a board-certified OB/GYN and a board-certified family medicine physician—generally provide only medication abortion at the Clinic. Three additional physicians—one board-certified OB/GYN and two board-certified family medicine physicians—provide both medication and procedural abortions at the Clinic.

13. In 2019, the Clinic provided 2,879 abortions. In 2020, the Clinic provided 2,663 abortions. The first part of 2021 is on par with these earlier years.

14. Approximately 5,000 patients per year obtain an abortion in Oklahoma.²

III. Overview of Abortion Care

15. Abortion is one of the safest and most common medical procedures performed in the United States.

16. There are generally two methods of providing abortion: procedural abortion³ and medication abortion.

17. Procedural abortion involves the use of instruments or medications to gently dilate (open) the cervix and evacuate the contents of the uterus. Procedural abortion is a straightforward procedure; it is almost always performed in an outpatient setting and involves local anesthesia or, at times, conscious sedation to make the patient more comfortable. It is typically a one-day procedure at the Clinic. Some patients may need additional time for dilation and so may have to come back to the Clinic for a second day; this is not routine but is indicated on occasion.

18. The most common form of medication abortion is a regimen of two prescription drugs, mifepristone and misoprostol, taken orally. The patient first takes Mifepristone, which is also known by its commercial name of Mifeprex. Misoprostol, which is also known by its commercial name of Cytotec, is taken 24 to 48 hours after mifepristone and causes the uterus to contract and expel its contents.

² Okla. State Dep't of Health, *Abortion Surveillance in Oklahoma: 2002-2020 Summary Report* (2020), <https://oklahoma.gov/content/dam/ok/en/health/health2/aem-documents/data-and-statistics/center-for-health-statistics/2020%20AbortionReport.pdf>.

³ "Procedural" abortion is also referred to as "surgical" abortion, but abortion is not what is commonly understood to be surgery. There is no incision and no need for general anesthesia or a sterile field.

19. In 2019, 72% of the abortions the Clinic provided were medication abortions; in 2020, that percentage rose to 81%. We expect that 2021 will also have a high percentage of medication abortions.

20. According to data collected by the Oklahoma State Department of Health, the proportion of abortions by medication abortion in Oklahoma has been steadily increasing.⁴ “In 2002, non-surgical abortions made up only 4.5 percent of all abortions performed in Oklahoma, while in 2020 non-surgical abortions made up 64.0 percent of all abortions.”⁵

21. Abortion is safer than carrying a pregnancy to term. Complications from abortion occur less than 1% of the time and are lower than the rate of complications involved in carrying a pregnancy to term.⁶ Nationally, the risk of death associated with childbirth is approximately 14 times higher than that associated with abortion, and pregnancy-related complications are more common with childbirth than abortion.⁷

IV. Abortion is Essential Healthcare

22. Abortion is essential healthcare. I provide abortion care because I have seen over my decades of practice that abortion is essential for women’s health and freedom. It enables women to direct their own lives and make decisions that are best for themselves and their families. Denying access to abortion would take that away. Abortion presents lower risks to patients than carrying a pregnancy to term.

⁴ See *supra* n.2.

⁵ *Id.*

⁶ Nat’l Acads. of Scis. Eng’g & Med., *The Safety and Quality of Abortion Care in the United States* (2018).

⁷ Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 (2 Part 1) *Obstetrics & Gynecology* 215 (2012), <https://pubmed.ncbi.nlm.nih.gov/22270271/>.

23. Our patients run the gamut of personal experience. We have patients who come from other states, already have children, have poor health, have had complications in prior pregnancies, and experience intimate partner violence, among many other types of patients. Most of our patients, however, are poor or low-income.

24. As a physician at the Clinic, I am familiar with the reasons why women seek our abortion services. While I feel it is my role to provide safe medical care without judgment and so generally would not ask patients why they are terminating a pregnancy, Oklahoma law requires me to do so. The reasons my patients share include, for example, that they have low incomes and/or already have children and feel they cannot adequately parent and support a child or additional children. Other patients seek abortion because continuing a pregnancy poses risks to their physical safety or health. Regardless of the specific circumstances underlying a patient's decision to have an abortion, most patients are sure of their decision by the time they arrive at the Clinic, and I do not begin an abortion procedure until I ensure that the patient is certain of their decision.

V. Total Ban

25. I understand H.B. 1102 to define the provision of abortion care as "unprofessional conduct" for purposes of the Oklahoma Board of Medical Licensure and Supervision and of the Oklahoma State Board of Osteopathic Examiners, unless the abortion falls within a narrow exception.

26. I understand that continuing to provide abortion care if H.B. 1102 were to go into effect could lead to the suspension or permanent revocation of my license to practice medicine in Oklahoma, as well as fines. I understand that this could jeopardize my license to practice medicine in Texas as well.

27. I would not provide abortion care in violation of the total ban in light of these professional licensure and civil penalties.

28. If H.B. 1102 were to go into effect, it would cut off access to abortion care in Oklahoma entirely—forcing patients to attempt to seek care in another state if they are able or, for many patients, forcing them to carry their pregnancies to term.

VI. 6-Week Ban

29. I understand that the 6-week ban turns on the detection of a “heartbeat” and prohibits performing or inducing an abortion “without first detecting whether or not [the] unborn child has a heartbeat.” HB 2441 § 1(A). No abortion may be performed where a “heartbeat” has been determined to be “detectable.” HB 2441 § 1(A). H.B. 2441 defines “detectable heartbeat” as “embryonic or fetal cardiac activity or the steady or repetitive rhythmic contract of the heart within the gestational sac.” HB 2441 § 1(B).

30. In a typically developing embryo, cells that eventually form the basis for development of the heart later in pregnancy produce cardiac activity that is generally detectable via ultrasound beginning at approximately 6 weeks LMP, though I have seen cardiac activity prior to 6 weeks LMP. H.B. 2441 thus bans abortion in Oklahoma after approximately 6 weeks LMP.

31. The cells that produce this early cardiac activity have not yet formed a “heart.” This activity is not a “heartbeat” in the lay sense, but, more accurately, electrical impulses present before development of the cardiovascular system. A developing pregnancy is properly referred to as an “embryo” until approximately 10 weeks LMP, when it becomes a “fetus.” The Act forbids abortion even when cardiac activity is detected in an embryo.

32. No embryo is viable at approximately 6 weeks LMP. For context, full-term pregnancies usually last approximately 40 weeks LMP. Viability is generally understood in

medical science as the point in gestation when a fetus has a reasonable likelihood of survival outside of the pregnant woman.

33. The medical consensus is that viability typically occurs around approximately 23-24 weeks LMP.

34. I understand that H.B. 2441 imposes criminal homicide liability for provision of abortion after approximately 6 weeks LMP, unless the abortion falls within H.B. 2441's narrow exception. I would not provide abortion care in violation of this ban.

35. There are many reasons why patients may not be able to arrive at a clinic by approximately 6 weeks LMP. Some patients do not realize they are pregnant until after approximately 6 weeks LMP. This includes patients who have irregular menstrual cycles; have certain medical conditions such as obesity or diabetes; have been using contraceptives; are breastfeeding; or are experiencing bleeding during early pregnancy, a common occurrence that is frequently and easily mistaken for a period. Other patients may not develop or recognize symptoms of early pregnancy.

36. Even for the patients who do realize they are pregnant before 6 weeks LMP, they would have a very small window to obtain an abortion. For a patient with regular monthly periods, fertilization typically occurs at 2 weeks LMP (two weeks after the first day of their last menstrual period). Thus, even a woman with a highly regular, four-week menstrual cycle would already be 4 weeks LMP when she misses her next period, generally the first clear indication of a possible pregnancy.

37. If patients are prohibited from obtaining an abortion after approximately 6 weeks LMP, this gives them *one to two weeks at most* to decide they want an abortion, arrange all of the necessary logistics, gather the money, schedule the appointment, and wait 72 hours after receiving

state-mandated information as required by Oklahoma law. This will become even more difficult if S.B. 778's two-trip requirement—described more below—goes into effect.⁸

38. Many of our patients will not be able to obtain an abortion within this narrow window. According to the Department of Health data, from 2002-2018, only 39% of abortions took place under 6 weeks LMP. Thus, the 6-week ban will prohibit a large majority of abortions in Oklahoma.⁹ Nationally, nearly two-thirds (63.8%) of abortions in 2018—the most recent year for which data is available—were performed after approximately 6 weeks LMP.¹⁰

39. The patients who can afford to do so will attempt to travel out of state. Those traveling out of state will need to pay additional travel and lodging costs and will likely face increased costs for the procedure. At later gestational ages, abortion is more expensive and may require a two-day procedure, instead of one. These patients would also experience increased risks to their health by the delay in access to abortion care.

40. For many patients, pregnancy creates serious symptoms and health risks. For people with comorbidities like asthma, hypertension, or diabetes, pregnancy exacerbates the symptoms and risk of an emergency. Even for people without comorbidities, common symptoms of pregnancy can include debilitating nausea, migraines, and dizziness. There is also a significant percentage of people who suffer perinatal depression or anxiety.

⁸ *Infra* Part VIII(B)(1).

⁹ This data was derived from a tool maintained online by the Oklahoma State Department of Health. Okla. State Dep't of Health, *OK2SHARE*, https://www.health.state.ok.us/stats/Vital_Statistics/ITOP/Final/Statistics.shtml (last visited August 29, 2021). The most recent Abortion Surveillance Report only reports abortions performed after 8 weeks LMP.

¹⁰ Ctrs. for Disease Control, *Abortion Surveillance—United States, 2018*, <https://www.cdc.gov/mmwr/volumes/69/ss/pdfs/ss6907a1-H.pdf> (Nov. 27, 2020).

41. Many of our patients will not be able to travel out of state to obtain an abortion. A significant percentage of the patients we see at the Clinic struggle to afford an abortion and receive some form of financial assistance. If these patients cannot access care at a clinic in Oklahoma, they may attempt to order pills through the mail to self-manage their abortions. We see patients who have attempted abortions themselves and failed, and the number of patients in this situation will only increase if H.B. 2441 takes effect.

42. If the 6-week ban takes effect, many of our patients will be forced to carry their pregnancies to term, having been denied the right to make decisions about their own bodies.

VII. OB/GYN Requirement

43. I understand H.B. 1904 to require physicians providing abortions to be board-certified in obstetrics and gynecology.

44. Three of the Clinic's six physicians are not board-certified in OB/GYN. They are board-certified in family medicine.

45. These three physicians have years of experience providing abortion care.

46. There is no health or safety reason for requiring OB/GYN board-certification in order to provide abortion care. Board-certification in OB/GYN is not relevant to the safe provision of abortion services, and training in abortion care is not a required part of becoming a board-certified OB/GYN.

47. A variety of physicians can and do safely and routinely provide abortion care. When hiring physicians, I look to a provider's training and experience in order to determine their ability to provide abortion care.

48. H.B. 1904 singles out abortion care. I am not aware of a requirement like this for any other outpatient procedure in Oklahoma.

49. If H.B. 1904 were to go into effect, half of the Clinic's providers would have to immediately stop providing abortion care. This includes two of the three physicians who regularly provide procedural abortions later in pregnancy.

50. This would dramatically limit access to abortion care in Oklahoma.

51. In order to obtain board-certification in OB/GYN, the Clinic's board-certified family medicine physicians would have to go through four years of OB/GYN residency, among other requirements. It is therefore not feasible for our board-certified family medicine physicians to obtain another board certification to be able to provide abortion care at the Clinic.

52. The Clinic has had difficulty hiring physicians due to the stigma around abortion and the harassment of providers, nationally and in Oklahoma. It is therefore similarly not feasible to replace our existing board-certified family medicine physicians with board-certified OB/GYNs.

53. The Clinic's facility is regularly picketed by protestors who harass the Clinic's physicians, staff, and patients. I am aware that, across the United States, abortion providers are regularly subjected to harassment, threats, and acts of violence.¹¹ Physicians have been murdered simply because they provide abortions.¹² Anti-abortion groups have historically sought to obtain and post on the internet the home addresses of abortion providers, the names of their family members, and their personal phone numbers. This information is used to identify abortion providers and pressure them into no longer providing abortion care.

54. I have personally experienced harassment as a result of anti-abortion protestors and activists. For example, I have been followed home in my car and threatened by an anti-abortion protestor. I must now take extra precautions to make sure I am not being followed. Protestors often

¹¹ Nat'l Abortion Fed'n, *2019 Violence and Disruption Statistics* (July 30, 2020), <https://prochoice.org/naf-releases-2019-violence-disruption-statistics/>.

¹² *Id.*

picketed my former residence, disturbing my family and our neighbors with signs and shouting. The tires on my car were slashed by anti-abortion protestors while it was parked at that residence.

55. Oklahoma is already a hostile place for patients seeking abortion care and the physicians and medical professionals who provide it, even before the challenged legislation was enacted.

56. The stigma of providing abortion care can also make it difficult to maintain or find an outside practice. For these reasons, the Clinic has had particular difficulty hiring local physicians, and most of the Clinic's physicians travel from out-of-state to provide abortion care at the Clinic.

VIII. Medication Abortion at the Clinic

57. I understand S.B. 778 and S.B. 779 to impose a host of onerous requirements that would drastically alter the Clinic's practices and limit access to abortion care.

A. Practice at the Clinic

58. Medication abortions provided at the Clinic follow the Food and Drug Administration ("FDA") approved regimen of mifepristone and misoprostol.¹³ The FDA has determined that this regimen is extremely safe and effective in terminating pregnancy—with a 97.4 percent overall success rate for terminating pregnancies up to 10 weeks LMP in the U.S.¹⁴ I also understand that medical evidence supports the use of the regimen up to 11 weeks LMP.

59. I provide medication abortion to patients at the Clinic in accordance with the FDA's current label for mifepristone. I administer mifepristone to patients who take the pill orally while they are at the Clinic and then instruct them to take the misoprostol buccally 24 to 48 hours later

¹³ *FDA Label for Mifeprex*, https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf.

¹⁴ *Id.*

at home or a location of their choosing. All physicians who provide medication abortion care at the Clinic follow this regimen, which has been shown to be extremely safe and effective.

60. Under Oklahoma law, one of the Clinic's physicians, or an agent of the Clinic's physicians, must provide specific state-mandated information to patients seeking abortion care at least 72 two hours before the patient's abortion procedure. This biased information must be given either by phone or in-person.¹⁵ Either I or one of the Clinic's other physicians is available to answer questions from the patient when the patient receives this information.

61. When patients arrive at the Clinic for an abortion, they undergo an ultrasound to confirm the gestational age of the pregnancy, have some lab tests, and receive counseling on the risks, benefits, and alternatives to abortion and the types of abortion procedures for which they are eligible. No abortion procedure begins until the patient has reviewed all of her options; received relevant, evidence-based information about the procedure; and provided informed consent to the procedure.

62. If a patient is eligible for and decides she wants a medication abortion, the patient is given a link to a video that further explains how the medications work, directions for taking the medications, and what to expect.

63. Medication abortion patients then meet with the providing physician, who will again explain the process, the medications used, the indication and precautions, and the treatment plan and go over any questions.

64. On the day they come in for their appointment, medication abortion patients are scheduled for a 7-14 day follow-up with a physician, though they are also able to contact the on-

¹⁵ 63 O.S. §§ 1-738.2-3.

call nurse at any time if they have any questions or concerns. If the patient does not show up for the follow-up appointment, the Clinic attempts to contact the patient.

65. In my experience, many women prefer medication abortion. Some patients 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. Other patients, including rape survivors, prefer medication abortion to a procedural abortion because they fear a procedure involving the insertion of instruments.

66. Medication abortion can also be medically preferred for some patients. For example, some women have medical conditions that make medication abortion a safer option, with a lower risk of complications and failure than procedural abortion. These conditions include anomalies of the reproductive and genital tract, such as large uterine fibroids, or physical conditions such as obesity. Such conditions are common in my experience.

B. Effects of S.B. 778 and S.B. 779

67. Given their sweeping nature, it is difficult to determine the full scope of the effects of these bills, but I have identified below some of the provisions that will be particularly problematic for patients and the Clinic.

68. If the Clinic, the Clinic's providers, and I are not able to comply with each and every provision, we will be barred entirely from providing medication abortion. Given the safety of medication abortion, there is no justification for these intrusive schemes that would essentially overhaul the way we provide medication abortion—imposing significant delays and other logistical burdens on patients and reducing access to abortion in Oklahoma.

1. S.B. 778

69. I understand S.B. 778 to impose dozens of medically unnecessary requirements, but these are some that I find particularly alarming:

70. **Two-Trip Requirement:** I understand S.B. 778 requires patients to have an ultrasound as part of the mandatory disclosures that must be given at least 72 hours prior to a medication abortion. Unless the patient obtains an ultrasound elsewhere from a reliable provider,¹⁶ this provision will require patients to make an additional—and medically unnecessary—visit to the Clinic for a medication abortion.

71. We also provide ultrasounds that are very reasonably priced because most of our patients are poor or low-income. Given the challenges our patients face in covering the cost of services, obtaining an ultrasound closer to their home might not be feasible because it will involve more expense.

72. Having to come to the Clinic twice for a medication abortion would be highly problematic for many patients, especially those who are hourly employees. One of the questions I hear most often from my patients about having an abortion is “when can I go back to work?” I believe that it would be difficult for some of my patients to have to get time off work or make other arrangements, such as finding childcare, so that they can make an additional visit to the Clinic.

73. This additional visit will also be especially harmful for women who travel long distances to get to the Clinic and will have to travel twice if S.B. 778 goes into effect.

¹⁶ I am particularly concerned about women obtaining ultrasounds from crisis pregnancy centers (“CPCs”), where they may be given inaccurate information about the gestational age of their pregnancy in an effort to delay them from seeking abortion care. This could cause women to miss the window for their preferred abortion method or to access abortion altogether—particularly if the 6-week ban goes into effect. In my practice, I routinely see patients who have been mis-dated at CPCs.

74. The two-trip requirement will compound existing obstacles, leading to further delays and barriers that may be insurmountable for some patients.

75. Given that medication abortion is only available at the Clinic up to 10 weeks LMP, I am very concerned patients will miss that window, including patients who prefer medication abortion or for whom medication abortion is medically indicated.

76. Providing this additional, medically unnecessary ultrasound would disrupt scheduling and create backlogs that will delay care. The Clinic would need to either hire additional staff or shift time away from patient care. This could limit access to abortion care, particularly if the mandatory disclosures, including the ultrasound, must be provided by a physician.

77. There is no health or safety reason for this requirement. Patients coming to the Clinic for a medication abortion already receive an ultrasound at the Clinic on the day of their appointment. Depending on where and when a patient gets the ultrasound as part of the mandatory disclosures, as well as the gestational age of the pregnancy, the patient may still need another ultrasound on the day of the medication abortion.

78. **Reporting Requirements:** I understand S.B. 778 requires for each medication abortion the identification of physicians providing medication abortion and referring providers, in addition to other information:

- Identity of qualified physician;
- Whether the medication abortion was completed at hospital/facility or alternative location;
- Referring physician, agency or service, if any;
- Pregnant patient's age and race;
- Number of previous pregnancies, live births, previous abortions;
- Probable gestational age;
- Drugs used, date provided, reason for abortion;
- Preexisting medical conditions which would complicate pregnancy;
- Whether patient returned for follow-up;
- Whether patient suffered from any complications; and
- Amount billed for complications.

79. I understand it to also designate the individual patient reports containing this information as “public records.” S.B. 778 § 8(H). My understanding is that existing law only publishes aggregated reports and has never made individual patient records “public records.”

80. Although S.B. 778 includes a vague disclaimer that “information or identifiers that would make it possible to identify, in any manner or under any circumstances, a woman who has obtained or seeks to obtain a chemical abortion,” S.B. 778 § 8(C), I have serious concerns that this law will risk the confidentiality of patient information. The information contained in these reports would expose a host of information about patients, including age, number of previous pregnancies, and pre-existing medical conditions. S.B. 778 § 8. These data could be used to identify individual patients even without other identifiers. This is particularly dangerous in the context of abortion, where abusive partners of pregnant women may seek to access patient information.

81. There is no protection for the identity of providers and referring providers, which must be reported. S.B. 778 § 8. This requirement will make it easier for people opposed to abortion to identify and harass abortion providers and referring providers. The requirement to report the name of a referring physician who may or may not be an abortion provider could also stop such physicians from referring their patients to the Clinic.

2. S.B. 779

82. I understand S.B. 779 to require any physicians providing medication abortion to register with the State, even though physicians at the Clinic are already licensed to practice medicine in Oklahoma. Like S.B. 778, S.B. 779 imposes a host of medically unnecessary requirements.

83. **Hospital Admitting Privileges:** I understand S.B. 779 to require a physician providing medication abortion to maintain hospital admitting privileges at a hospital in the county

or contiguous county where the medication abortion is provided—and to inform the patient of any hospital where the physician holds admitting privileges—or to enter into a written agreement with another physician. S.B. 779 § 8, § 7(11). If a physician opts for a written agreement with an associated physician, my understanding is that the associated physician must have admitting privileges and their agreement must meet a host of other conditions. S.B. 779 § 8.

84. There is no health or safety benefit to requiring admitting privileges as a condition for providing medication abortion.

85. Having hospital admitting privileges is not related to competence in providing abortion care. I do not think it is necessary to hold admitting privileges in Oklahoma because I do not treat patients in a hospital setting. Like physicians in other practice areas, I am able to recognize complications and make the determination of when to treat a patient in the Clinic and when to refer the patient to a hospital.

86. Additionally, complications from medication abortion are rare and, when they do arise, they generally occur after the patient has left the Clinic. The patient ingests the first medication, Mifepristone, at the Clinic, but takes the second medication, Misoprostol, at a location of their choosing.

87. The Clinic already has a protocol for how to handle complications, including in the rare event when a patient must be transferred.

88. Four of the Clinic's physicians, including myself, travel from out of state to provide care at the Clinic, making it even more difficult—if not impossible—for us to obtain privileges at a local hospital.

89. Further, it is unclear whether the Clinic would be able to find a local physician who would be willing to enter into an agreement like this. I am not aware of any physicians in Tulsa

who would be willing to enter into an agreement for purposes of this requirement, particularly in light of the stigma and harassment abortion providers face.¹⁷

90. I understand the law to require the providing physicians to submit a copy of the agreement to the State, which then submits a copy of that agreement to each hospital in the county. S.B. 779 § 8(2). Given the stigma of providing abortion care, this may exacerbate the difficulty of finding a provider willing to enter into such an agreement.

91. Accordingly, this requirement would immediately limit access—causing delays and preventing some patients from accessing their preferred abortion method.

92. **Reporting System:** I understand S.B. 779 § 9(A) to require the Oklahoma Board of Medical Licensure and Supervision and Oklahoma State Board of Osteopathic Examiners to create an electronically based reporting system for certified physicians to report annually certain information, including:

- The number of patients served;
- Age of patients served;
- Race of patients served;
- County and state of residence of patients served;
- If the patient resides outside the United States, city and country of residence;
- County and state of service;
- A list of staff attending patients including licensing numbers and evidence of other qualifications;
- Each medication used or provided per patient, by date;
- Any known complications or adverse events, and how they were addressed, by date; and
- Unresolved cases.

93. I understand this reporting system is “also [to] be used by emergency department physicians and private physicians who treat post-abortion complications.” S.B. 779 § 9(B).

¹⁷ *Supra* Part VII.

94. I understand S.B. 779 contains language requiring physicians to protect any personally identifiable information from disclosure, S.B. 779 § 9(C), but I have concerns that such a reporting system raises confidentiality concerns for my patients and the Clinic's physicians and staff.

95. **Complaint Portal:** I understand S.B. 779 to also direct Oklahoma's physician licensing boards to develop a "complaint portal" for patients, pharmacy, nursing and medical professions, and the public to submit information about potential violations. S.B. 779 § 13(B). I understand S.B. 779 to require the names of all the fully licensed physicians certified under Oklahoma's medication abortion program to be listed on this portal. S.B. 779 § 13(D).

96. Given the threats of harassment and violence against abortion providers, I have serious concerns about listing the names of medication abortion providers in this way.

IX. Conclusion

97. The Acts carry criminal, civil, and professional licensure penalties. Should they go into effect, they Clinic and I will not provide care in violation of them.

98. Each of the total ban, 6-week ban, and OB/GYN requirement would immediately dramatically reduce, if not eliminate entirely, access to abortion in Oklahoma if it were to go into effect, and the medication abortion bills would impose a host of requirements that add additional obstacles, cause delays, and likely push medication abortion out of reach for some patients. This reduced access will delay care, forcing some people to have abortions later in pregnancy and preventing others from accessing care altogether.

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

Dated this 31 day of August, 2021.

Alan Braid, M.D.

Alan Braid, M.D.

NOTARY

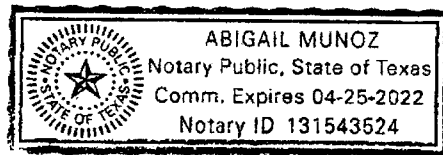


EXHIBIT A

ALAN RICHARD BRAID, M.D.

BOARD CERTIFIED OBSTETRICS AND GYNECOLOGY

DIPLOMATE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

1963 Weequahic High School, Newark, N.J.

1967 Pennsylvania State University B.S

1972 University of Texas Health Science Center, M.D.

1972-1976 UTHSCSA residency Obstetrics and Gynecology

1976-1978 Dover Air Force Base, Rank of Major, Ob-Gyn Service

1978-2010 Private practice Ob-Gyn, San Antonio, Texas

2010-2012 Owner and Medical Director, Reproductive Services of San Antonio

2012-present Owner and Medical Director, Alamo Women's Reproductive Services

2015-present Owner and Medical Director, Alamo City Surgery Center, San Antonio, Texas

2018-present Owner, Tulsa Women's Reproductive Clinic, Tulsa, Oklahoma

EXHIBIT 3

**IN THE DISTRICT COURT OF OKLAHOMA COUNTY
STATE OF OKLAHOMA**

OKLAHOMA CALL FOR REPRODUCTIVE JUSTICE, on behalf of itself and its members; TULSA WOMEN'S REPRODUCTIVE CLINIC, LLC, on behalf of itself, its physicians, and staff; ALAN BRAID, M.D., on behalf of himself and his patients; COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, INC., on behalf of itself, its physicians, and staff; and PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, on behalf of itself, its physicians, and staff,
Plaintiffs,

v.

JOHN O'CONNOR, in his official capacity as Attorney General for the State of Oklahoma; DAVID PRATER, in his official capacity as District Attorney for Oklahoma County; STEVE KUNZWEILER, in his official capacity as District Attorney for Tulsa County; LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; KATIE TEMPLETON, in her official capacity as President of the Oklahoma State Board of Osteopathic Examiners; LANCE FRYE, in his official capacity as the Commissioner of the Oklahoma State Board of Health; and JUSTIN WILSON, in his official capacity as the President of the Oklahoma State Board of Pharmacy; as well as their employees, agents, and successors,
Defendants.

CASE NO. _____

**DECLARATION OF JOSHUA YAP, MD., MPH., AAHIVS
IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY INJUNCTION**

Joshua Yap, M.D., MPH, AAHIVS, declares the following under penalty of perjury:

1. I am employed by and provide health care services at Plaintiff Planned Parenthood Arkansas & Eastern Oklahoma (“PPAEO”)’s Tulsa, Oklahoma health center. I also provide health care services on a regular basis at Plaintiff Comprehensive Health of Planned Parenthood Great Plains, Inc. (“CHPPGP”)’s Oklahoma City health center. I submit this declaration in support of Plaintiffs’ Motion for Temporary Injunction to enjoin enforcement of Oklahoma House Bills No. 1102 (“H.B. 1102” or “Total Ban”); No. 2441 (“H.B. 2441” or “Six Week Ban”); Oklahoma Senate Bills No. 778 (“S.B. 778”) and No. 779 (“S.B. 779”) (collectively, “Medication Abortion Restrictions”); and Oklahoma House Bill No. 1904 (“H.B. 1904” or “OB/GYN Requirement”) (collectively, “the Challenged Laws”), which were enacted during the 2021 Oklahoma legislative session.

2. I am a board-certified Family Medicine physician and am licensed to practice medicine in Oklahoma, Kansas, Arkansas, Missouri, and California. I graduated from medical school at Loma Linda University in 2015. I completed my internship and dual residency in Family Medicine and Preventive Medicine at Montefiore Medical Center and Albert Einstein College of Medicine in 2019. I obtained my Master of Public Health degree in 2019 from the City University of New York School of Public Health.

3. I am familiar with the Challenged Laws’ requirements. The effect of these laws would be devastating to my patients’ ability to exercise their constitutional right to choose abortion and prevent PPAEO and CHPPGP (collectively, “Planned Parenthood Plaintiffs”), and me personally, from being able to fulfill our mission of providing high-quality, safe, and effective health care to the over 1,300 patients who obtain abortion care from Planned Parenthood Plaintiffs in Oklahoma each year.

Planned Parenthood Plaintiffs' Health Centers' Provision of Abortion Care

4. I am employed by and provide health care at PPAEO's Tulsa health center and I also provide care at CHPPGP's Oklahoma City health center.

5. Planned Parenthood Plaintiffs' Oklahoma health centers provide a broad range of sexual and reproductive health care and education services, including abortion care, contraception care and counseling, pregnancy testing and prenatal referrals, testing and treatment for sexually transmitted infections, PrEP, PEP, clinical breast exams, breast and cervical cancer screenings, colposcopies and biopsies, condyloma treatment, and gender-affirming hormone therapy and hormone replacement therapy.

6. Our health centers provide procedural abortion care¹ for patients through approximately 17 weeks gestational age, as measured from the first day of a patient's last menstrual period ("LMP"), and medication abortion up through 77 days gestational age.

7. Both of our health centers are licensed by the Oklahoma State Department of Health. Our health center labs have Clinical Laboratory Improvement Amendments (CLIA) certification. Both health centers also keep prescription pharmaceuticals in a drug room licensed by the Oklahoma State Board of Pharmacy.

Our Patients

8. Our patients seek abortion care for a variety of reasons, including, for example, being unable to divert time, financial resources, or caretaking resources away from existing children or other family members; being unable to absorb the additional financial burden; having become pregnant as the result of rape; having an abusive partner; being unable to take time away

¹ This is also sometimes referred to as "surgical abortion," though it does not involve making any incisions.

from their educational or career paths; being in the military and on the cusp of deployment; and medical reasons, including, for example, a fetal diagnosis, a history of previous high-risk pregnancies, or cancer diagnosis that requires choosing between effective treatment and pregnancy.

9. Most of our patients are firm in their decision when they come to us. We only provide abortion care to patients when we are confident that they are certain that abortion is the right option for them and after obtaining their informed consent. Our patients undergo an informed consent process that includes an explanation and discussion of the methods of abortion and their respective risks and benefits, as well as alternatives to abortion, such as parenting and adoption. We also answer any questions the patient has. At every step of the process, we make sure our patients know that we support them and their decision, whatever it may be. After a patient obtains an abortion, that patient is sent home with discharge instructions and information about how to contact us 24/7 with any concerns or questions. We try to follow up with all medication abortion patients to see how they are doing, answer any questions, and determine whether further follow-up care is needed.

10. At least 30% of our patients live near or below the federal poverty line and many more are low-income. As a result, laws that restrict or impose barriers on access to abortion disproportionately affect people who have the fewest resources to find alternate ways to obtain the care they need or to overcome barriers to access.

11. According to the American Community Survey conducted by the U.S. Census Bureau, Black Oklahomans are more than twice as likely to live in poverty (28.2%) than their white counterparts (12.6%).²

12. According to the Oklahoma State Department of Health, Black women also access abortion care at higher rates than their white counterparts.³ This trend holds true for people obtaining abortions at Planned Parenthood Plaintiffs' Oklahoma health centers.

13. Thus, any laws that restrict or impose barriers on access to abortion disproportionately affect Black people in Oklahoma who both access abortion services at a higher rate and have fewer resources to find alternate means of finding care or overcoming barriers to abortion access.

14. Many of our patients already have a difficult time accessing abortion care. Many have difficulty obtaining the funds for an abortion, obtaining transportation to a health center (particularly as Oklahoma has virtually no public transportation outside its major cities), being able to get and afford to take a day off from work, and finding childcare for existing children.

15. All of these logistics need to be arranged before a patient can obtain an abortion and that all takes time. Moreover, the State of Oklahoma already requires my patients to wait at least 72 hours before they can obtain an abortion. Adding to the logistical obstacles patients need to overcome to access an abortion will simply worsen and compound the delays they already face.

16. Abortion is a time-sensitive medical procedure. Delays can result in patients being pushed past the point when they can obtain a medication abortion, even if that would be the

² United States Census Bureau, *Poverty Status in the Past 12 Months, 2019 Community Survey 1-year estimates* (2019), <https://data.census.gov/cedsci/table?q=oklahoma%20poverty%20race&tid=ACST1Y2019.S1701>

³ Oklahoma State Department of Health, *Abortion Surveillance in Oklahoma, 2002–2019 Summary Report 7* (2019), <https://www.ok.gov/health2/documents/2019%20ITOP%20Report.pdf>

preferable method for that patient. Delays can also push patients beyond the point at which they can obtain abortion care at all in Oklahoma.

Our Providers

17. I have provided abortion care for five years. I obtained training in abortion care during my dual residency at Montefiore Medical Center and Albert Einstein College of Medicine, as well as during an extended training in abortion care in Illinois and in Texas.

18. I have been providing health care services, including abortion care, at CHPPGP's Oklahoma City health center since August of 2019.

19. Over time, CHPPGP was able to hire other physicians to provide care in Oklahoma City, though all are out-of-state doctors who travel to Oklahoma to provide care a few days each per month.

20. I trained and onboarded many of the physicians providing care at CHPPGP's Oklahoma City health center, including ensuring their practical competency in providing abortion care.

21. Once other physicians began providing abortion care in Oklahoma City, I was able to begin providing care at PPAEO's Tulsa health center, where I am the only physician who provides abortion care. Starting in September, I will resume providing care in Oklahoma City a few days per month.

Difficulty Finding Providers

22. We have faced many challenges hiring physicians willing to provide health care in Oklahoma. During 2019 and the beginning of 2020, while I was the sole Planned Parenthood provider in Oklahoma, we sought to hire physicians who lived in or were willing to move to

Oklahoma to provide care at CHPPGP's Oklahoma City health center full-time. We were unable to find a single physician willing to do so.

23. There are many reasons why physicians are hesitant to provide abortion care in Oklahoma, including fear of harassment by anti-abortion protestors. Some of the physicians with whom Planned Parenthood met regarding the Oklahoma City position expressed specific concerns about security, harassment of themselves or family members, and potential stigma from future employers in Oklahoma.

24. I have first-hand experience with such harassment. For example, around March of this year, an anti-abortion protester would pace outside one of our health centers with a large rifle slung over his shoulder, apparently trying to film staff and patients as they walked into and out of the health center. We were forced to use large umbrellas to escort our patients inside and shield their faces to protect their privacy.

25. In another instance earlier this year, someone followed my car out of the clinic. I had to drive around the block in circles until the car stopped following me, for fear that the protestors were trying to follow me home to find out where I live.

26. In Oklahoma City, we have been forced to call the police because anti-abortion protesters were attempting to film patients inside the health center through the windows. We have also had a protester dressed as the grim reaper scare patients as they entered the health center. Our nearby facility in Edmond, which does not provide abortion services, was vandalized in October 2020.

27. Though we were unable to secure full-time physicians for our Oklahoma City health center, we are lucky enough to have found physicians willing to travel into Oklahoma from

out-of-state to provide abortion care. As a result, I have time to provide care to more patients in Tulsa.

28. As discussed in more detail below, none of our providers have admitting privileges in Oklahoma City. Only one of our providers in either location is a board-certified OB/GYN, and she provides care in Oklahoma only a few days per month.

Total Ban

29. I understand that the Total Ban mandates medical licensure penalties for a physician who provides an abortion—at any stage of pregnancy and for any reason except for an exceedingly narrow set of exceptions for life-threatening medical conditions. These penalties include, at minimum, a one-year licensure suspension, along with possible fines.

30. The Planned Parenthood Plaintiff health centers in Oklahoma have cared for over 1,300 patients already this calendar year—that is 1,300 people who would have been barred from accessing abortion care in Oklahoma under this law.

31. If the Total Ban were to take effect and abortion services were to become unavailable in Oklahoma, people would be forced to seek abortion care out of state or would be forced to carry their unwanted pregnancies to term, including potentially high-risk pregnancies. Some may seek to terminate their pregnancies outside the medical system altogether.

32. Many of our patients will have a difficult, if not impossible, time traveling out of state, particularly those living with abusive partners or abusive parents, and those who already struggle to travel to an in-state clinic because of financial or logistical hurdles.

33. Traveling out of state will only compound the existing barriers to accessing care my patients already face and may well result in substantial delays in obtaining care.

34. Many of the states contiguous to Oklahoma, including Texas, Arkansas, and Missouri, have passed near-total abortion bans, highlighting the importance to my Oklahoma patients of being able to obtain safe, legal abortion care within their home state.

Six Week Ban

35. I understand the Six Week Ban defines as homicide the provision of abortions performed where embryonic cardiac activity is detectable by ultrasound, which is generally around six weeks gestation, long before the embryo develops into a fetus that is viable (i.e., that can sustain life outside of the uterus).

36. The majority of our abortion patients are later than six weeks gestation when we see them. This is because many patients do not yet know that they are pregnant at six weeks gestation. Symptoms of pregnancy, including nausea and missed periods, are not present or consistent among all patients, nor are they always related to pregnancy (meaning a patient, given their medical history, may not have reason to believe that a particular symptom, such as nausea or a missed period, necessarily means they are pregnant; for example, many patients have irregular periods and some do not get periods at all). And, even for those who do know they are pregnant, it is often not possible to immediately obtain an appointment and travel to one of our health centers.

37. Thus, the Six Week Ban would have a devastating effect on most of our patients, denying them the ability to seek safe, legal abortion care in their home state, forcing them to either travel out of state or to continue with an unwanted pregnancy, even for those with potentially high-risk pregnancies.

OB/GYN Requirement

38. I am board certified in Family Medicine. I am not board-certified in Obstetrics and Gynecology.

39. I obtained substantial abortion training during my residency in New York City, and further advanced training at abortion centers in Illinois and Texas. I completed multiple rotations in abortion care, including an extended rotation in second trimester abortion care. I also completed rotations in labor and delivery and outpatient OB/GYN care.

40. I oversaw much of the training and onboarding for all but one of the physicians who provide abortion care at Planned Parenthood Plaintiffs' Oklahoma health centers. As with all of the physicians we hire, these physicians all had prior training and experience in abortion care, and we ensured their competency in abortion before they were privileged to provide such care to patients, as is our practice.

41. As discussed above, aside from the one physician who is a board-certified OB/GYN and provides care at CHPPGP's Oklahoma City health center on only a part-time basis, the other providers at that health center, including myself, are all board-certified in Family Medicine.

42. There is no medical reason to restrict the provision of abortion care only to physicians who are board-certified in Obstetrics and Gynecology.

43. I am not aware of any specialized abortion care training that a board-certified OB/GYN obtains that I did not obtain during my residency as a Family Practice physician.

44. Abortion complications are rare. However, as in any medical practice, some complications may arise that may require referral to another provider. Though I have never needed to do so in my own practice, in the event that a complication arose that would require referral to another physician, any family medicine physician could make such a referral.

45. The same and similar methods of abortion care provided to patients seeking an induced abortion (*i.e.*, people who seek to terminate a pregnancy) are routinely provided to patients

experiencing a spontaneous abortion (*i.e.*, people experiencing a miscarriage). There is no medical reason to require different qualifications to provide that care to one set of patients than to another.

46. If the OB/GYN Requirement went into effect, Planned Parenthood Plaintiffs would immediately become unable to provide abortion care to the vast majority of our patients in Oklahoma. I do not know when, if ever, we would be able to hire sufficient OB/GYNs willing to provide in Oklahoma to be able to serve the number of abortion patients we are currently serving. The care provided by the one OB/GYN who currently travels to Oklahoma only a few days per month is extremely limited because of her commitment to patients in other states.

47. Obtaining board certification in Obstetrics and Gynecology does not simply involve preparing for and taking the board exams, though just taking the exams alone would also be onerous and would take me away from my patients. Board certification requires that, in order to be eligible to take the board exams, one must complete a certain number of years training in the specialty in question through a residency certified in the relevant specialty. In essence, I would have to apply to, be accepted to, and then complete another medical residency, which would take years.

48. As noted above, if the OB/GYN Requirement were to go into effect, Planned Parenthood Plaintiffs would have to turn away the vast majority of abortion patients we currently see.

Medication Abortion Restrictions

49. I understand S.B. 778 and 779 (“Medication Abortion Restrictions”) to impose a host of restrictions on the provision of medication abortion care, creating various qualification and certification requirements for doctors, pharmacies, and pharmaceutical manufacturers, as well as detailed and onerous reporting requirements. Specifically, I understand that S.B. 778 requires,

among other things, that people must obtain an ultrasound at least 72 hours prior to obtaining an abortion; and that S.B. 779 (the physician, manufacturer, and pharmacy certification bill) requires, among other things, that physicians who provide abortions must have admitting privileges at a nearby hospital or a written agreement with a physician who does. I also understand that S.B. 779 prohibits the provision of medication abortion beyond 70 days gestational age.

50. Patients at or less than 77 days gestation who are seeking an abortion at one of our Oklahoma health centers may choose either a medication abortion or an in-clinic abortion. Medication abortion involves taking two medications: mifepristone, which disrupts the development of the pregnancy, and misoprostol, which causes the uterus to contract and the pregnancy to be passed in a manner similar to a miscarriage.

51. By contrast, in-clinic abortions at this stage in pregnancy involve gently opening the cervix and using light suction to empty the contents of the uterus (generally referred to as “aspiration”).

52. Medication abortion is safe and effective, with an over 97% effectiveness rate for pregnancies up to 77 days gestational age.⁴

53. Many of my patients who can choose to have either an in-clinic or medication abortion prefer medication abortion. Some patients indicate a preference for medication abortion because: it feels more natural to them as it works much like a miscarriage; they can choose where and when (within 48 hours of taking the first medication) to take the second medication; they may prefer the option of being able to do it in the comfort of their own homes, on their own schedules; and they may have experienced sexual assault or other trauma or suffer from vaginismus and would

⁴ National Abortion Federation, *Clinical Policy Guidelines for Abortion Care* 18 (2020), https://5aa1b2xfmfh2e2mk03kk8rsx-wpengine.netdna-ssl.com/wp-content/uploads/2020_CPGs.pdf

like to avoid to the extent possible having speculums and other instruments inserted in their vaginas.

54. In 2021 so far, approximately 85% of abortions obtained at Planned Parenthood Plaintiffs' Oklahoma health centers have been medication abortion.

55. If the Medication Abortion Restrictions went into effect, even if abortion were otherwise legal in Oklahoma, the vast majority of our patients would be affected, and some would potentially be prevented from obtaining the method of abortion that is right for them. *None* of our patients would be able to obtain a medication abortion after 70 days gestation, despite the fact that evidence-based clinical practice permits its use up to 77 days.⁵

56. While I will attempt to illustrate the devastating effects the Medication Abortion Restrictions would have on the provision of abortion care in Oklahoma, as detailed below, the maze of requirements in the bills likely will have many more wide-ranging effects than I have been able to fully illustrate here. For example, S.B. 779 requires certain pharmaceutical manufacturers of abortion-inducing drugs to register with the state of Oklahoma and submit to audits, which may imperil the availability of medication abortion in Oklahoma entirely if manufacturers are unable or unwilling to obtain such certification or submit to the required audit. The Medication Abortion Restrictions also include arduous reporting requirements, some of which are to be designated "public records," which require such detailed information about a patient's medical history that patients may be identifiable, which may put some patients at risk from abusive partners or family members. These reporting requirements also require abortion providers to identify any physician or agency who referred a patient to us, which may subject those physicians and agencies to threats and harassment and may ultimately create a chilling effect where physicians and agencies are

⁵ National Abortion Federation, *supra* note 4.

unwilling to refer patients to abortion providers, even at a patient's request or when doing so is in the patient's best interest.

57. Thus, while there are likely to be many more effects of the Medication Abortion Restrictions than I can list here, I will attempt to describe some of the Medication Abortion Restrictions' requirements that will have the most devastating impact on access to abortion in Oklahoma.

Two Trip Requirement

58. I understand that S.B. 778 would require medication abortion patients to obtain an ultrasound at least 72 hours prior to obtaining an abortion. For most patients, this would mean two trips to our health centers, which will double the travel, financial, and logistical burdens already experienced by our patients. Indeed, even patients who do live near our health centers will face logistical challenges, potentially needing to take two days off from work or arrange childcare on two different days.

59. There is no medical reason for a patient to obtain an ultrasound prior to the day of their abortion. The language of S.B. 778 indicates that this ultrasound is intended to "confirm gestational age," but there is no reason that this needs to occur prior to the day of the abortion. We already confirm the gestational age of our patients' pregnancies on the day of their medication abortion.

60. The majority of our abortion patients who reside in Oklahoma do not live in the same city as the health center where they obtain abortion care, and many live in rural areas. As a result, travel to and from our health centers can often be difficult for patients, both because of the time they must spend travelling to the health center, as well as the associated logistical hurdles of taking time off from work, obtaining transportation, and obtaining childcare.

61. Moreover, the logistical issues of adding a medically unnecessary appointment would affect all of our clinical processes. Our health centers would have to accommodate twice the number of appointments per patient—one for the ultrasound and one at least 72 hours later for the abortion. In order to maintain the same availability of care to patients, front desk staff would have to check in and assist patients for twice the number of appointments per abortion patient. Waiting rooms would be filled with patients there only for medically unnecessary ultrasounds.

62. If S.B. 778 goes into effect, some patients will be required to obtain two ultrasounds if patients experience a delay of more than seven days between their statutorily required ultrasound and the day of their actual abortion. If more than seven days have elapsed since an ultrasound, our procedures require the patient to obtain a second ultrasound.

63. If the Six Week Ban were also to go into effect, then those patients who are delayed past six weeks—because of the logistical burdens of having to come to the health center twice and/or because of congestion at the health center caused by the 72-hour ultrasound requirement—would be denied care in Oklahoma entirely, forcing them to seek care out of state or forego care entirely, carrying an unwanted pregnancy to term or seeking a pregnancy termination outside the medical system.

64. The delays would also cause some patients who would otherwise be eligible for a medication abortion to be delayed beyond the window in which we provide it at our health centers (currently up to 77 days gestation, reduced to 70 days if S.B. 779 is permitted to go into effect) and would thus lose the option of obtaining a medication abortion in Oklahoma.

65. Similarly, some patients who are currently able to obtain an abortion at one of our Oklahoma health centers may well be so delayed that they will be beyond the stage in pregnancy where we provide care in Oklahoma. This would require these patients to overcome yet more

logistical and financial hurdles including finding overnight lodging near an out-of-state health center.

Admitting Privileges Requirement

66. I understand that S.B. 779 would prohibit a physician from providing medication abortion to patients unless the physician either has admitting privileges at a hospital in the same or contiguous county where the medication abortion is provided or has a written agreement with a physician who does.

67. There is no medical reason for this requirement.

68. I have never had to transfer any abortion patient from a health center to a hospital. This is not surprising as both medication and in-clinic abortion methods are safe and highly effective.

69. Moreover, because medication abortion involves completing the abortion outside of the health center (after the second medication is taken), even if a patient were to suffer a complication, it would almost certainly not occur at the time the patient takes the first medication at the health center.

70. All medication abortion patients are advised in their discharge papers to contact us, if they have any questions or concerns after they have left one of our health centers and are given contact information to reach us 24/7. If such a patient calls during clinic hours, the patient will be offered an appointment as soon as possible (usually a same- or next-day appointment), or if we believe they need more immediate attention, we will refer them directly to a hospital, as discussed below. If they come into the health center, we speak to and examine the patient, answer any and all questions, and provide follow-up care as appropriate.

71. If a medication abortion patient calls with concerns when the health center is closed, or if the patient cannot return for an appointment (due to distance or other logistical barriers) we provide them with advice based on their symptoms and, if we feel it is appropriate, we refer them to a nearby hospital. We try to follow up with any patient who calls with these types of concerns to see how they are doing and determine if their symptoms have resolved. If the patient went to a hospital, we seek the patient's permission to contact the hospital to communicate with them about the patient's care and to ensure we have relevant information about the patient's condition. We have never been prevented from communicating with a hospital about a patient because I or any of our other physicians lack admitting privileges to that hospital.

72. In the rare event that a patient needs hospital care (or needs care off-hours, when the health center is closed), patients can obtain such care in hospitals regardless of whether their abortion provider has admitting privileges at that hospital. Hospitals can, and routinely do, communicate with their patients' outside physicians regardless of whether those outside physicians happen to have admitting privileges at that hospital.

73. While I have admitting privileges at a hospital in Tulsa, where I primarily work, I do not have nor do I believe I would be able to obtain such privileges in Oklahoma City or any contiguous county.

74. The other physicians who provide care at CHPPGP's Oklahoma City health center are all out-of-state physicians, none of whom have admitting privileges at a hospital in or near Oklahoma City. Because their primary practice is not in Oklahoma, it is highly unlikely that these out-of-state physicians would be able to obtain admitting privileges at an Oklahoma hospital.

75. I understand the law permits physicians, in lieu of obtaining admitting privileges, to have a contract with another "associated physician" who does have such privileges, but that the

“State Department of Health shall annually submit a copy of the written agreement. . . to each hospital located in the county or a county that is contiguous to the county where the abortion was performed.” S.B. 779 § 8(2)(d)(1). There is no medical basis for such a requirement, and I can think of no other area of medicine where a similar requirement is imposed. Indeed, this requirement appears designed to harass both physicians who agree to be associated with abortion providers and the hospitals that are willing to give such associated physicians admitting privileges, as it requires notice sent to all local hospitals, not only the hospital where the physician has privileges.

76. If the Medication Abortion Restrictions went into effect, because none of our physicians have admitting privileges in Oklahoma City or a contiguous county, none of our patients would be able to access medication abortion in our Oklahoma City health center—a health center that provided medication abortion to over 1,000 patients in 2020.

Conclusion

77. I have devoted my career to providing high-quality sexual and reproductive health care. I moved to Oklahoma because there was a need for physicians who could provide such care—including, in particular, abortion care. I have come to love the state that is now my home and I care deeply for my patients.

78. The Acts seek to prevent health care providers, including myself, as well as Planned Parenthood Plaintiffs, from advancing our mission to provide high-quality, evidence-based abortion care in a supportive, safe, and non-judgmental environment to those of our patients who choose abortion.

79. The Acts seek to prevent patients from being able to access critical and time-sensitive health care, and from being able to exercise their constitutional right to choose to terminate their pregnancies.

80. If the Challenged Laws go into effect, many of my patients will not be able to easily seek abortion care outside of Oklahoma. Those of my patients with the fewest resources will be the most severely impacted. I fear that many will not be able to obtain safe abortion care at all and will either seek to terminate their pregnancies themselves, outside the medical system, or be forced to carry unwanted pregnancies to term. Many of my patients already face extreme barriers to accessing the care they need, and so those who ultimately would be able to travel out of state would not be able to do so without substantial sacrifices. Those of my patients who are seeking abortion care in the context of intimate partner violence or other family violence will have to risk more than they already do in order to travel out of state to end their unwanted pregnancies.

81. The Challenged Laws come with truly staggering penalties for violations, including criminal sanction (violations are considered “homicide” under the Six Week Ban; under the Medication Abortion Restrictions, unintentional violations constitute misdemeanors and intentional or reckless violations constitute felonies); professional sanction, including suspension or revocation of one’s Oklahoma medical license; and mind-boggling financial penalties, including civil liability for punitive damages and attorneys’ fees, as well as penalties for violations of S.B. 779’s certification requirements of \$5,000,000 per violation for medication abortion distributors and \$250,000 per violation for physicians.

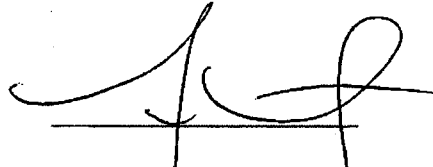
82. I would not be willing to risk any of these penalties. If the Total Ban, Six Week Ban, OB/GYN Requirement, and the Medication Abortion Restrictions went into effect, no Planned Parenthood physician would risk providing care in violation of those statutes. If the Total Ban went into effect, Planned Parenthood Plaintiffs would be forced to cease providing abortions in Oklahoma. If the Six Week Ban went into effect, we would likely have to turn away the majority of our abortion patients. If the OB/GYN Requirement went into effect, we would have to turn

away even more patients, as four out of five of our doctors, and our only provider in Tulsa (me), would no longer be able to provide abortion care in Oklahoma. If S.B. 779 went into effect, I would no longer be able to provide medication abortion care in Oklahoma City due to the medically unnecessary admitting privileges requirement, and there are no other physicians at Planned Parenthood health centers who could provide medication abortion care there in my stead. If S.B. 778 went into effect, all of our patients would be forced to delay medication abortion due to the medically unnecessary early ultrasound requirement, and at least some patients would be unable to obtain medication abortions in Oklahoma.

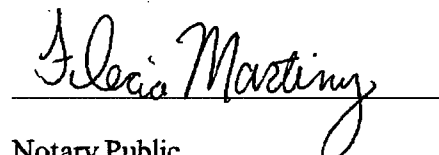
83. I know of no other area of medicine where physicians are subjected to criminal penalties, civil liability and professional sanctions for practicing medicine consistent with professional guidelines and evidence-based medicine.

84. Not only will the Challenged Laws prevent people in Oklahoma from being able to control their own reproduction, but they also provide astonishingly few exceptions. The Challenged Laws provide no exceptions for people who are pregnant as a result of rape or incest, or for people who would suffer severe psychological trauma if forced to carry an unwanted pregnancy to term. Indeed, the Six Week Ban explicitly notes that no exceptions to the abortion prohibition exists for patients “based on a claim or diagnosis that the woman will engage in conduct which she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function.” H.B. 2441 § 1(A). I find in this language an acknowledgment that people will go to extreme lengths to control their own bodies and their futures; and that depriving them of this ability, as the Challenged Laws seek to do, will lead to severe and irreparable harm to pregnant people in Oklahoma.

Dated: September 1, 2021


Joshua Yap, M.D., MPH, AAHIVS

Sworn before me this 1st
day of September 2021


Notary Public

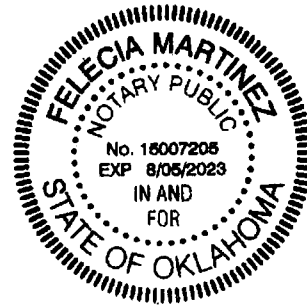


EXHIBIT 4

**IN THE DISTRICT COURT OF OKLAHOMA COUNTY
STATE OF OKLAHOMA**

OKLAHOMA CALL FOR REPRODUCTIVE JUSTICE, on behalf of itself and its members; TULSA WOMEN'S REPRODUCTIVE CLINIC, LLC, on behalf of itself, its physicians, its staff, and its patients; ALAN BRAID, M.D., on behalf of himself and his patients; COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, INC., on behalf of itself, its physicians, its staff, and its patients; and PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, on behalf of itself, its physicians, its staff, and its patients,

Plaintiffs,

v.

JOHN O'CONNOR, in his official capacity as Attorney General for the State of Oklahoma; DAVID PRATER, in his official capacity as District Attorney for Oklahoma County; STEVE KUNZWEILER, in his official capacity as District Attorney for Tulsa County; LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; KATIE TEMPLETON, in her official capacity as President of the Oklahoma State Board of Osteopathic Examiners; LANCE FRYE, in his official capacity as the Commissioner of the Oklahoma State Board of Health; and JUSTIN WILSON, in his official capacity as the President of the Oklahoma State Board of Pharmacy; as well as their employees, agents, and successors,

Defendants.

CASE NO. _____

**AFFDAVIT OF USHMA UPADHYAY, PH.D., M.P.H. IN SUPPORT OF PLAINTIFFS'
MOTION FOR TEMPORARY INJUNCTION**

Dr. Ushma Upadhyay declares and states the following:

Introduction

1. As discussed more below, I am an Associate Professor in Residence, in the Department of Obstetrics & Reproductive Sciences, at the University of California, San Francisco, School of Medicine (“UCSF”).

2. I submit this declaration in support of Plaintiffs’ Motion for Temporary Injunction against enforcement of Oklahoma HB 1102, HB 2441, HB 1904, SB 778, and SB 779.

3. Based on my personal knowledge, training, and expertise as a researcher who has generated some of the most rigorous and significant research on the safety of abortion and the barriers that women face in obtaining an abortion, it is my opinion that the challenged requirements have no medical justification whatsoever and will only constrain access to an essential healthcare service.

Professional Credentials and Experience

4. I have been faculty at UCSF since 2009. I am based at Advancing New Standards in Reproductive Health (“ANSIRH”), a program that conducts high-quality and multidisciplinary research on a range of issues related to people’s sexual and reproductive lives. I am also Director of Research for the University of California, Global Health Institute’s Center of Expertise on Women’s Health, Gender, and Empowerment.

5. Prior to my current position and since obtaining my Ph.D., I held various research positions with UCSF, and prior to UCSF, with the New York City Department of Health and Mental Hygiene, Division of Epidemiology. I received a Master of Public Health from the Columbia School of Public Health in 1998 and a Ph.D. from Johns Hopkins School of Public Health in 2006.

6. My research focuses on improving access to high-quality contraception and abortion care and women's empowerment and gender equity in the context of reproductive health. I have expertise in abortion safety, abortion access in the U.S., and medication abortion, among other areas.

7. My training is in epidemiologic and demographic research methods. I use quantitative study designs. I have published over 80 peer-reviewed research papers in a variety of high-quality medical journals, including the Journal of the American Medical Association (JAMA), PLOS Medicine, and the American Journal of Public Health.

8. I have published some of the seminal studies on the safety of abortion, which have demonstrated that abortion is safe and that many laws restricting abortion access lack medical justification. In 2015, I published a paper on abortion safety, based on statistical data from California's Medicaid program, which is considered the best available evidence we have on the safety of abortion today.¹ In 2019, I published an expanded paper using national data.² Also, in 2018, I published a retrospective case series investigating the effects of admitting privileges

¹ Ushma D. Upadhyay, et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125(1) Obstetrics & Gynecology 175-83 (2015) [hereinafter, "2015 ED Study"], available at https://journals.lww.com/greenjournal/Fulltext/2015/01000/Incidence_of_Emergency_Department_Visits_and.29.aspx.

² Ushma D. Upadhyay, et al., *Abortion-Related Emergency Department Visits in the United States: An Analysis of a National Emergency Department Sample*, 16(88) BMC Med. 1-11 (2018) [hereinafter, "2018 National ED Study"], available at <https://bmcmmedicine.biomedcentral.com/articles/10.1186/s12916-018-1072-0>.

requirements for abortion providers, finding that admitting privileges requirements do not improve patient safety.³

9. I have been invited to give lectures and presentations on topics related to reproductive health, including abortion safety, by organizations, such as the North American Forum on Family Planning, the Annual Meeting of the Population Association of America, and the American Public Health Association, and universities, such as the University of California, Los Angeles, Emory University, and Brown University.

10. A copy of my curriculum vitae with a complete listing of my professional background, experience, and publications is attached hereto as Exhibit A.

Abortion Care in the United States

11. There are generally two methods of abortion—medication and procedural.

12. The most common form of medication abortion is a regimen of two prescription medications, mifepristone and misoprostol. Mifepristone, also known by its commercial name Mifeprex, was first approved by the U.S. Food and Drug Administration (FDA) in 2000 as an effective alternative to procedural abortion in early pregnancy when used in conjunction with misoprostol. The FDA has confirmed that this protocol is extremely safe and effective in terminating pregnancy.

13. Procedural abortion involves the use of instruments and/or medications to gently dilate (open) the cervix and remove the contents of the uterus. It is almost always performed in an outpatient setting and involves local anesthesia and sometimes conscious sedation.

³ Ushma D. Upadhyay, et al., *Admitting Privileges and Hospital-Based Care After Presenting for Abortion: A Retrospective Case Series*, 54(2) Health Serv. Rsch. 425-36 (2018/2019), available at <https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.13080>.

14. A wide array of providers perform abortion care, including physicians of different specialties such as emergency medicine, family medicine, and obstetrics and gynecology (OB/GYN). First trimester procedural and medication abortions can also be safely performed by advanced practice clinicians (APCs), such as nurse practitioners.

The Challenged Laws

15. I understand that H.B. 1102 bans abortion entirely by declaring that providing abortion constitutes unprofessional conduct such that physicians who provide abortions are subject to, at a minimum, suspension of licensure for one year. I further understand that H.B. 2441 bans abortion at approximately six weeks in pregnancy, making the provision of an abortion in violation of the act a homicide.

16. I understand that H.B. 1904 will dramatically reduce the number of abortion providers in the state without any medical justification by barring highly skilled and competent physicians, including family medicine doctors, from providing abortions because they are not board-certified OB/GYNs.

17. I understand that S.B. 778 imposes medically unjustified and burdensome requirements solely for doctors providing medication abortion. For example, I understand it requires patients to get an ultrasound 72 hours in advance of obtaining a medication abortion, which is medically unnecessary and irrelevant to the safe and effective provision of medication abortion.

18. I understand that S.B. 779 requires various agencies to impose an extensive certification system for manufacturers, distributors, and providers of medication abortion. Components of this scheme include requiring physicians to have admitting privileges at a local

hospital or a contract with a physician who does and limiting the accessibility of medication abortion to 10 weeks from a patient's last menstrual period ("LMP").

Abortion Care is Extraordinarily Safe

19. Abortion is one of the most studied procedures in outpatient medicine. It is extremely safe with a low rate of complications. A recent, robust analysis of the full spectrum of abortion care in the U.S. performed by the National Academies of Sciences, Engineering, and Medicine, a national entity that brings together diverse perspectives to examine public health issues, concluded that abortion continues to be one of safest, most common medical procedures performed in the nation.⁴ Serious complications are exceedingly rare; "in the vast majority of studies, they occur in fewer than 1 percent of abortions."⁵

20. My robust research on abortion safety was cited in the National Academies' findings on the issue. In my team's study of a nationally representative sample of emergency department visits, encompassing nearly 200 million weighted emergency department visits, abortion-related visits represented 0.01% of visits among women of reproductive age.⁶ Half of the abortion-related visits received only observation, which did not require any treatment at all.⁷

⁴ National Academies of Science, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States*, 2018, available at <http://nap.edu/24950> [hereinafter, "NAS, Safety and Quality of Abortion Care"]; *id.* at 77 ("The clinical evidence makes clear that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective.").

⁵ *Id.*

⁶ 2018 National ED Study at 5, 7.

⁷ *Id.* at 6.

Serious complications, requiring blood transfusion, surgery, or an overnight stay accounted for 20.3% of the 0.01% of visits—that is 0.002% of all emergency department visits.⁸

21. The major incident rate for abortion is lower than published rates for pregnancy, as well as for other common procedures, such as colonoscopy, wisdom tooth removal, and tonsillectomy.⁹

22. The vast majority of abortions are performed in an office or clinic setting.¹⁰ Indeed, my 2015 study found that 97% of abortions in our sample occurred at outpatient facilities.¹¹

23. The research also shows that a wide array of providers can safely perform abortion care. For example, my team conducted a study that shows that APCs can provide first trimester procedural abortions as safely as physicians.¹²

24. There is no medical or scientific reason to restrict abortion provision only to OB/GYNs, given that a wide variety of clinicians can receive training in abortion care and go on to provide safe and effective abortion care.

25. There is no evidence or other reason to believe that OB/GYNs provide care more safely than either family medicine physicians or APCs.

⁸ *Id.* at 7.

⁹ *Id.* at 8; NAS, Safety and Quality of Abortion Care, at 75-76.

¹⁰ Sarah C. M. Roberts, et al., *Association of Facility Type with Procedural-Related Morbidities and Adverse Events Among Patients Undergoing Induced Abortions*, 319(24) JAMA 2497-2506 (2018), available at <https://jamanetwork.com/journals/jama/fullarticle/2685987>.

¹¹ 2015 ED Study at 177.

¹² Tracy A. Weitz, et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants under a California Legal Waiver*, 103(3) Am. J. Pub. Health 454-61 (2013), available at <https://ajph.aphapublications.org/doi/10.2105/AJPH.2012.301159>.

26. Indeed, according to the Academies, “[t]he clinical evidence presented . . . on the provision of safe and high-quality abortion care stands in contrast to the extensive regulatory requirements that state laws impose on the provision of abortion services.”¹³

Medication Abortion

27. Medication Abortion is one of the safest medication regimens in medicine today.¹⁴ My 2015 study found that less than one third of 1 percent of medication abortions resulted in a serious complication.¹⁵

28. Research consistently shows that medication abortion is safer than many other common medications, including antibiotics and over-the-counter drugs, such as Advil or Tylenol.¹⁶

29. Given the robust evidence of the safety of medication abortion, medicine is moving away from medically unnecessary restrictions on access to the regimen.¹⁷ For example, the FDA is currently reconsidering the mifepristone Risk Evaluation and Mitigation Strategy (“REMS”), which sets forth certain restrictions on the provision of the medication.¹⁸ In 2016, the FDA dropped

¹³ NAS, Safety and Quality of Abortion Care, at 77.

¹⁴ ANSIRH, *Analysis of Medication Abortion Risk and the FDA Report “Mifepristone U.S. Post-Marketing Adverse Events Summary through 12/31/2018”*, Issue Brief (Apr. 2019), available at https://www.ansirh.org/sites/default/files/publications/files/mifepristone_safety_4-23-2019.pdf.

¹⁵ 2015 ED Study at 181.

¹⁶ NAS, Safety and Quality of Abortion Care, at 58, 79; see also source cited *supra* at n.14.

¹⁷ Ushma D. Upadhyay, et. al, *Safety and Efficacy of Telehealth Medication Abortions in the US During the COVID-19 Pandemic*, 4(8) JAMA Network Open 1-3 (2021), available at <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2783451>.

¹⁸ American Civil Liberties Union, *Press Release: FDA Announces Long Sought-After Review of Harmful Restrictions on Medication Abortion* (May 7, 2021), available at

a requirement for in-person follow up visits for medication abortion patients based on mounting evidence that the requirement was not medically necessary.¹⁹ In 2016, the FDA also updated the mifepristone label to match the evidence-based practice at the time to provide the medication abortion regimen up to 10 weeks LMP.²⁰ Evidence now supports the use of the regimen up to 11 weeks LMP.²¹

30. Evidence shows that provision of medication abortion without pre-abortion ultrasound or other tests can also be safe and effective.²²

31. During the COVID pandemic, some abortion providers sought to provide medication abortion with reduced physical contact, to reduce the risk of viral COVID transmission. Evidence has shown that this care has proven safe and effective.²³

<https://www.aclu.org/press-releases/fda-announces-long-sought-after-review-harmful-restrictions-medication-abortion>.

¹⁹ FDA, *Questions and Answers on Mifeprex*, <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifeprex>, accessed August 9, 2021; Wesley Clark, et al., *Alternatives to a Routine Follow-Up Visit for Early Medical Abortion*, 115(2 pt. 1) *Obstetrics & Gynecology* 264-72 (2010), available at https://journals.lww.com/greenjournal/Fulltext/2010/02000/Alternatives_to_a_Routine_Follow_Up_Visit_for.10.aspx.

²⁰ See source cited *supra* at n.14.

²¹ National Abortion Federation, *2020 Clinical Policy Guidelines for Abortion Care*, at 16-17, available at https://5aa1b2xfmfh2e2mk03kk8rsx-wpengine.netdna-ssl.com/wp-content/uploads/2020_CPGs.pdf.

²² See source cited *supra* at n.17.

²³ *Id.*; Erica Chong, et al., *Expansion of a Direct-to-Patient Telemedicine Abortion Service in the United States and Experience during the COVID-19 Pandemic*, 104(1) *Contraception* 43-48 (2021), available at <https://www.sciencedirect.com/science/article/abs/pii/S0010782421000913>; Ushma D. Upadhyay, et al., *Adoption of No-Test and Telehealth Medication Abortion Care among Independent Abortion Providers in Response to COVID-19*, 2 *Contraception X* 100049 (2020), available at <https://pubmed.ncbi.nlm.nih.gov/33305255/>.

32. There is no medical reason to subject medication abortion to the kinds of specialized, onerous schemes enacted in S.B. 778 or S.B. 779. The requirements of these schemes are irrelevant to the safety or efficacy of medication abortion.

33. Mandating that an ultrasound be conducted at least 72 hours in advance of a medication abortion provides no medical benefit and only serves to restrict access to care. I understand that Plaintiffs already conduct ultrasounds for abortion patients on the day of their abortion. Requiring that the ultrasound be conducted days earlier, and requiring patients to make two medical appointments at least three days apart, provides no medical benefit whatsoever.

34. Specialized provider qualifications like those in these bills, including the admitting privileges requirement, are also medically irrelevant to patient care. As previously noted, I have authored an article concerning admitting privileges requirements for abortion care. We looked at data from abortion providing facilities before and after laws went into effect requiring admitting privileges for abortion providers. While the incidence of hospital referral was rare, as would be expected, the data we reviewed showed no difference in patient care or the means by which patients obtained hospital-based care after admitting privileges requirements went into effect, nor did we find any increased coordination between abortion providers and hospitals after admitting privileges requirements went into effect.²⁴

35. The myriad requirements related to reporting complications that I understand are part of S.B. 778 and 779 are also untethered to the safe or effective provision of medication abortion. Medication abortion is safe and effective, and there is no medical reason to subject it to unique and burdensome regulation.

²⁴ See source cited *supra* at n.3.

Access to Abortion is Essential for Women's Health

36. Although the U.S. abortion rate has declined, abortion is still a common and necessary procedure—1 in 4 American women will obtain an abortion in their lifetime.²⁵

37. Abortion is increasingly concentrated among poor and low-income women who live at or below 100-200% of the federal poverty level and who accounted for 75% of abortion patients in 2014.²⁶

38. Abortion is a time-sensitive medical service, but patients often face significant delays in accessing care due to barriers imposed by state law restrictions,²⁷ which increase the amount of travel and/or impose other logistical barriers. Research consistently shows that access to abortion care is very sensitive to increases in logistical burdens—even small increases in travel distance or congestion at abortion facilities due to reduced access can stop patients from getting care and force them to carry an unwanted pregnancy to term.²⁸

²⁵ Guttmacher Institute, *Abortion is a Common Experience for U.S. Women, Despite Dramatic Declines in Rates* (Oct. 19, 2017), available at <https://www.guttmacher.org/news-release/2017/abortion-common-experience-us-women-despite-dramatic-declines-rates>.

²⁶ *Id.*

²⁷ Jason M. Lindo & Mayra Pineda-Torres, *New Evidence on the Effects of Mandatory Waiting Periods for Abortion*, Working Paper No. 26228, Nat'l Bureau of Econ. Rsch. (June 2021), available at http://people.tamu.edu/~jlindo/MandatoryWaitingPeriods_LindoPinedaTorres.pdf.

²⁸ Caitlin Myers, *Cooling off or Burdened? The Effects of Mandatory Waiting Periods on Abortions and Births*, IZA D.P. No. 14434, IZA Inst. of Labor Econ. (June 2021), available at <http://ftp.iza.org/dp14434.pdf>; Daniel Grossman, *The Use of Public Health Evidence in Whole Woman's Health v Hellerstedt*, 177(2) JAMA Intern Med. 155-156 (2017), available at <https://pubmed.ncbi.nlm.nih.gov/27820613/>; Jason M. Lindo, et al., *How Far Is Too Far? New Evidence on Abortion Clinic Closures, Access, and Abortions*, 55(4) J. Hum. Res. 1137-60, Univ. of Wis. Press (2020), available at <http://jhr.uwpress.org/content/early/2019/05/01/jhr.55.4.1217-9254R3.abstract>; Troy Quast, et al., *Abortion Facility Closings and Abortion Rates in Texas*, 54 Inquiry 1-7 (2017), available at <https://pubmed.ncbi.nlm.nih.gov/28351188/>; Stefanie Fischer, et al., *The Impacts of Reduced Access to Abortion and Family Planning Services on Abortions, Births, and Contraceptive Purchases*, 167 J. Pub. Econ. 43-68 (2018), available at

39. Many states, including Oklahoma, already have limited access to care. A paper on which I was a senior author showed that in 2017, there were only 4 publicly advertising abortion clinics in Oklahoma, corresponding to 220,527 women of reproductive age per facility.²⁹ I understand that today, there are the same number of clinics, which are concentrated in two metropolitan areas. Thus, patients already must travel very long distances to reach an abortion provider. Patients who live in rural areas often must travel 50 to 100 miles, and in some cases 200 miles or more, to obtain abortion care.³⁰ Having to travel long distances and expend resources is associated with delays in obtaining care, different types of care, increased costs, and stress.³¹ In my team's national study of people denied an abortion, travel and procedure costs were the most

<https://www.sciencedirect.com/science/article/abs/pii/S0047272718301531>; Joanna Venator & Jason Fletcher, *Undue Burden Beyond Texas: An Analysis of Abortion Clinic Closures, Births, and Abortions in Wisconsin*, 40(3) J. Policy Analysis & Mgmt. 774-813 (2021), available at <https://onlinelibrary.wiley.com/doi/10.1002/pam.22263>.

²⁹ Alice F. Cartwright, et al., *Identifying National Availability of Abortion Care and Distance from Major US Cities: Systematic Online Search*, 20(5) J. Med. Internet Rsch. e186 (2018), available at <https://pubmed.ncbi.nlm.nih.gov/29759954/>.

³⁰ Liza Fuentes & Jenna Jerman, *Distance Traveled to Obtain Clinical Abortion Care in the United States and Reasons for Clinic Choice*, 28(12) J. Women's Health 1623-31 (2018), available at <https://pubmed.ncbi.nlm.nih.gov/31282804/>; Jonathon Bearak, et al., *Disparities and Change over Time in Distance Women Would Need to Travel to have an Abortion in the USA: A Spatial Analysis*, 2(11) Lancet Pub. Health 493-500 (2017), available at <https://pubmed.ncbi.nlm.nih.gov/29253373/>; Caitlin Myers, et al., *Predicted Changes in Abortion Access and Incidence in a Post-Roe World*, 100(5) Contraception 367-73 (2019), available at <https://pubmed.ncbi.nlm.nih.gov/31376381/>.

³¹ Mickey Sperlich, et al., *Reflections of Stress in US Abortion Narratives*, 20(5) J. Soc. Work 533-56 (2020), available at <https://journals.sagepub.com/doi/abs/10.1177/1468017319852602>; Caitlin Gerdt, et al., *Impact of Clinic Closures on Women Obtaining Abortion Services after Implementation of a Restrictive Law in Texas*, 106(5) Am. J. Public Health 857-64 (2016), available at <http://sites.utexas.edu/txpep/files/2017/04/Gerdt-Impact-of-Clinic-Closures-AJPH-pre-print-2016.pdf>; Jill Barr-Walker, et al., *Experiences of Women Who Travel For Abortion: A Mixed Methods Systematic Review*, 14(4) PLoS One (2019), available at <https://pubmed.ncbi.nlm.nih.gov/30964860/>.

common reason for delay in reaching care.³² Low-income people in particular experience these barriers, including difficulties taking time off work to seek care (and therefore foregoing needed income), finding childcare, and paying for gas or other transportation costs.³³

40. Although remaining a straightforward procedure, abortion becomes more complex and expensive as pregnancy advances—delays in accessing care can prevent some people from being able to choose a medication abortion, even if that would have been the right choice for them; push people from an earlier to a later procedure; and/or push people from a one-day to a two-day procedure.³⁴ Delays can also push patients beyond the time during which they may obtain an abortion at all.³⁵

41. Although abortion remains safe, risk can increase if patients are forced to receive later procedures.³⁶ People with certain medical conditions may experience worsening health with advancing pregnancy, such as people with hypertension.³⁷

42. Research shows that patients denied access to a wanted abortion experience worse outcomes than patients who were able to receive abortion care.

³² Ushma Upadhyay, et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104(9) Am. J. Pub. Health 1687-94 (2014), available at <https://pubmed.ncbi.nlm.nih.gov/23948000/>.

³³ See sources cited *supra* at nn.27-28.

³⁴ *Id.*

³⁵ *Id.*

³⁶ 2018 National ED Study at 5, 7.

³⁷ Elizabeth Raymond & David Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2 pt. 1) Obstetrics & Gynecology 215-19 (2012), available at <https://pubmed.ncbi.nlm.nih.gov/22270271/>; 2018 National ED Study at 92, 94.

43. Employing data from the Turnaway Study,³⁸ researchers confirmed that carrying an unwanted pregnancy to term is far riskier to women's physical health than having an abortion. In the short term, women giving birth after being denied an abortion experience more potentially life-threatening complications, such as preeclampsia and postpartum hemorrhage, than those who were able to obtain an abortion.³⁹ Over five years, women who give birth after being denied an abortion report more chronic pain and rate their overall health as worse, than women who were able to obtain an abortion.⁴⁰

44. Researchers also found that women who were denied an abortion were more likely to experience economic hardship and financial insecurity than women who obtained a wanted abortion. Women were more likely to live in poverty for four years after being denied an

³⁸ The Turnaway Study is a longitudinal study by researchers at UCSF/ANSIRH examining the effects of unintended pregnancy on women's lives. I was a member of the group of researchers who published papers as part of the Turnaway Study. The study followed about a thousand women who sought abortions at 30 facilities across the country, some of whom obtained an abortion and some of whom were denied an abortion due to gestational limits. Participants were interviewed several times over a five-year period on topics including physical and mental health, employment and educational attainment, relationship status, contraceptive use, emotions about pregnancy and abortion, and other related topics. In all, researchers conducted almost 8,000 interviews for the project. Researchers also gathered information on the women's children—those the women had prior and subsequent to the obtained or denied abortion, and those resulting from the unintended pregnancy.

³⁹ Caitlin Gerds, et al., *Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth After an Unwanted Pregnancy*, 261(1) *Women's Health Issues* 55-59 (2016), available at <https://www.ibisreproductivehealth.org/publications/side-effects-physical-health-consequences-and-mortality-associated-abortion-and-birth>.

⁴⁰ Lauren J. Ralph, et al., *Self-Reported Physical Health of Women Who Did and Did Not Terminate Pregnancy After Seeking Abortion Services: A Cohort Study*, 171(4) *Annals of Internal Med.*, 238-47 (2019), available at <https://ucdavis.pure.elsevier.com/en/publications/self-reported-physical-health-of-women-who-did-and-did-not-termin>.

abortion.⁴¹ Women who were denied an abortion had lower levels of employment for the first four years of the study⁴² and were more likely to report not having “enough money to pay for basic living expenses like food, housing, and transportation” than those who obtained an abortion.⁴³

45. I was the lead author and a co-author on studies based on this data that examined women’s one-year⁴⁴ and five-year plans for their own lives.⁴⁵ These plans included child-related plans, financial plans, educational plans, and relationship plans.⁴⁶ This research showed that women who received an abortion were much more likely than women who were denied a wanted abortion to set aspirational plans.⁴⁷

⁴¹ 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 407-13 (2018), available at <https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304247>; see also Diana Greene Foster, *The Turnaway Study: Ten Years, a Thousand Women, and the Consequences of Having—or Being Denied—an Abortion* at 176 (2020) [hereinafter, “The Turnaway Study: Ten Years”] (“Six months after our study participants either terminated their pregnancies or gave birth, 61% of those who were turned away were living below the poverty level, compared to 45% who received the abortion . . . They [also] remain significantly more likely to be poor for the next four years”).

⁴² The Turnaway Study: Ten Years at 175 (“It took four years for women who were turned away and gave birth to catch up to the level of employment experienced by women just under the limit who received their abortion. Those years of either steady or unstable employment can have significant impact on women’s and their families’ economic well-being.”).

⁴³ *Id.* at 175, 202.

⁴⁴ Ushma D. Upadhyay, et al., *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15(102) BMC Women’s Health 1-10 (2015), available at <https://bmcmwomenshealth.biomedcentral.com/articles/10.1186/s12905-015-0259-1>.

⁴⁵ Molly A. McCarthy, et al., *The Effect of Receiving Versus Being Denied an Abortion on Making and Achieving Aspirational 5-Year Life Plans*, 46(3) BMJ Sexual & Reproductive Health 177-83 (2020), available at <https://srh.bmj.com/content/46/3/177.abstract>.

⁴⁶ See sources cited supra at nn.44-45.

⁴⁷ *Id.*

46. Although abortion is not associated with any mental health harms, women denied abortions experience stress around being denied care.⁴⁸

47. Women who are unable to access abortion also may be at increased risk of continued violence from intimate partners.⁴⁹

48. The Turnaway Study also demonstrated that when women are denied abortions, their existing families suffer. Researchers found measurable differences in the economic wellbeing and development of existing children as compared to those whose mothers were denied a wanted abortion. Conversely, children born later to women who were able to get an abortion experienced more economic security and better maternal bonding than the children born because a woman was denied an abortion.⁵⁰

49. Abortion is a common, safe, and effective medical procedure, whether provided by medication or procedure. It is also vital for people who seek it in determining the course of their lives and in forming their families. Delaying and denying access to this care, as the challenged laws will do, hurts patients and their families, including their current and future children.

⁴⁸ Laura F. Harris, et al., *Perceived Stress and Emotional Social Support Among Women Who Are Denied or Receive Abortions in the United States: A Prospective Cohort Study*, 14(76) BMC Med. 1-11 (2014), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4080695/>.

⁴⁹ Sarah C. M. Roberts, et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12(144) BMC Med. 1-7 (2014), available at <https://pubmed.ncbi.nlm.nih.gov/25262880/>.

⁵⁰ Diana Greene Foster, et al., *Comparison of Health, Development, Maternal Bonding, and Poverty Among Children Born after Denial of Abortion vs After Pregnancies Subsequent to an Abortion*, 172(11) JAMA Pediatrics 1053-60 (2018), available at <https://pubmed.ncbi.nlm.nih.gov/30193363/>; Diana Greene Foster, et al., *Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children*, 205 J. Pediatrics, 183-89 (2018), available at <https://pubmed.ncbi.nlm.nih.gov/30389101/>.

50. I am unaware of any other area of medicine where a healthcare provider can face severe criminal and licensing penalties, such as a homicide charges, for providing safe and effective medical care in accordance with FDA requirements and the guidance of leading medical organizations.

DATED:

8/31/21


Ushma Upadhyay, Ph.D., M.P.H.

NOTARY

Please see attached.

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 Contra Costa

Subscribed and sworn to (or affirmed) before me on this 31st
day of August, 2021, by Margaret Allensworth Fohl,
Notary Public

proved to me on the basis of satisfactory evidence to be the
person(s) who appeared before me.



(Seal)

Signature

A handwritten signature in black ink, appearing to read "Margaret Allensworth Fohl", written over a horizontal line.

EXHIBIT A

University of California, San Francisco
CURRICULUM VITAE

Name: Ushma D. Upadhyay, PhD, MPH

Position: Associate Professor In Residence, Step 3
Obstetrics, Gynecology & Reproductive Sciences
School of Medicine

Address: Box 1744
1330 Broadway, Suite 1100
University of California, San Francisco
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Voice: 510-986-8946
Fax: 510-986-8960
Email: ushma.upadhyay@ucsf.edu
Web: <http://www.ansirh.org/staff-members/ushma-upadhyay>

EDUCATION

1991 - 1995	The American University Washington, DC	BA	Public Communication & International Studies	
1993 - 1993	Universidad Mayor de San Simon Cochabamba, Bolivia		Sustainable Development	
1996 - 1998	Columbia School of Public Health New York, NY	MPH	Population & Family Health	
2000 - 2006	Johns Hopkins Bloomberg School of Public Health Baltimore, MD	PhD	Reproductive, Perinatal & Women's Health	Advisor: Michelle J Hindin, PhD

LICENSES, CERTIFICATION

2006	Johns Hopkins University Research Coordinator Training Program, Baltimore, MD
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PRINCIPAL POSITIONS HELD

1996 - 1997	Columbia-Presbyterian Hospital, New York, NY	Clinic Counselor	Family Planning Clinic
1997 - 1998	New York State Department of Health, New York, NY	Research Assistant	Maternal and Child Health Bureau
1998 - 1999	Johns Hopkins Bloomberg School of Public Health, Baltimore, MD	Research Analyst	Center for Communication Programs

1999 - 2005	Johns Hopkins Bloomberg School of Public Health, Baltimore, MD	Technical Writer	Center for Communication Programs
2005 - 2007	Johns Hopkins Bloomberg School of Public Health, Baltimore, MD	Associate Editor	Center for Communication Programs
2007 - 2008	New York City Department of Health and Mental Hygiene, New York	Postdoctoral Research Scientist	Division of Epidemiology
2009 - 2009	University of California, San Francisco, CA	Specialist, Step II	Dept. of Ob, Gyn & Reproductive Sci.
2009 - 2011	University of California, San Francisco, CA	Assistant Research Scientist, Step III	Dept. of Ob, Gyn & Reproductive Sci.
2011 - 2013	University of California, San Francisco, CA	Assistant Research Scientist, Step IV	Dept. of Ob, Gyn & Reproductive Sci.
2013 - 2016	University of California, San Francisco, CA	Assistant Adjunct Professor, Step III	Dept. of Ob, Gyn & Reproductive Sci.
2016 - present	University of California, San Francisco, CA	Associate Professor in Residence, Step I	Dept. of Ob, Gyn & Reproductive Sci.
2018 - present	University of California, San Francisco, CA	Associate Professor in Residence, Step II	Dept. of Ob, Gyn & Reproductive Sci.

OTHER POSITIONS HELD CONCURRENTLY

2008 - 2010	New York City Department of Health and Mental Hygiene, New York	Consultant	Division of Epidemiology
2009 - 2009	IFC Macro International, Calverton, MD	Fellow	Demographic and Health Surveys
2010 - 2011	UC Center of Expertise on Women's Health and Empowerment, San Francisco, CA	Postdoctoral Fellow	UC Global Health Institute

HONORS AND AWARDS

1991	Cum Laude, Dean's List	American University
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1997	Graduate Research Assistantship	Columbia University
2005	Endowed Fellowship in Family Planning and Reproductive Health	Johns Hopkins Bloomberg School of Public Health
2007	New Investigator in Global Health Award	Global Health Council
2011	Best Research Poster	National Abortion Federation
2013	Outstanding Researcher Award	Society of Family Planning
2015	Best Research Poster	National Abortion Federation
2017	Best Oral Abstract	National Abortion Federation
2021	Psychosocial Workshop	Most Engagement Award

KEYWORDS/AREAS OF INTEREST

Sexual and reproductive health, women's empowerment, women's reproductive autonomy, relationship power, gender-based power, access to contraception, contraceptive technology, medical barriers to contraceptive provision, international family planning programs, abortion restrictions, abortion procedures, complications of abortion, medication abortion, adolescent sexual behavior, South Asian American health.

PROFESSIONAL ACTIVITIES

MEMBERSHIPS

- 1997 - present South Asian Women's Network, Member
- 1999 - present South Asian Public Health Association, Member
- 2003 - present Population Association of America, Member
- 2009 - present Society of Family Planning, Fellow

SERVICE TO PROFESSIONAL ORGANIZATIONS

1999 - 2004	South Asian Public Health Association	Founding Board Member
2005 - 2012	American Public Health Association	Abstract Reviewer
2005 - 2012	South Asian Women's Network (sawnet.org)	Moderator
2021 - 2021	California Abortion Alliance	Board Member

SERVICE TO PROFESSIONAL PUBLICATIONS

- 2007 - 2007 Feminist Economics Ad hoc referee
- 2007 - 2010 AIDS Care Ad hoc referee
- 2010 - 2010 Economics and Human Biology Ad hoc referee
- 2008 - 2011 Journal of Adolescence Ad hoc referee

2009 - 2011	Asia-Pacific Journal of Public Health	Ad hoc referee
2011 - 2011	BMC Health Services Research	Ad hoc referee
2011 - 2011	Demography	Ad hoc referee
2012 - 2012	Stigma Research and Action	Ad hoc referee
2012 - 2013	Culture, Health and Sexuality	Ad hoc referee
2006 - present	Journal of Adolescent Health	Ad hoc referee
2007 - present	Studies in Family Planning	Ad hoc referee
2010 - present	International Perspectives in Reproductive and Sexual Health	Ad hoc referee
2012 - present	Contraception	Ad hoc referee
2014 - present	Journal of Immigrant and Minority Health	Ad hoc referee
2015 - present	Archives of Sexual Behavior	Ad hoc referee
2017 - present	The Journal of Sex Research	Ad hoc referee

INVITED PRESENTATIONS - INTERNATIONAL

2005	World Health Organization Family Planning Technical Meeting, Geneva, Switzerland	Presenter
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INVITED PRESENTATIONS - NATIONAL

2005	Reproductive Health Materials Working Group, Washington, DC	Presenter
2011	Public Health Institute, International Women's Day	Web Lecturer
2012	Mifepristone Medical Abortion Meeting, New York City	Presenter
2014	National Abortion Federation Regional Meeting, Cleveland, OH	Presenter
2015	Bridging the Divide Medication Abortion Roundtable, Washington, DC	Presenter
2016	Population Association of America, Washington, DC	Discussant
2016	Population Association of America, Washington, DC	Session Chair
2017	Population Association of America, Chicago, IL	Discussant
2017	Population Association of America, Chicago, IL	Session Chair
2017	Society of Family Planning, Atlanta, GA	Moderator
2018	Population Association of America, Denver, CO	Session Chair
2018	North American Forum on Family Planning, New Orleans, LA	Presenter & Planner

2019	Abortion Care Network Annual Conference, Las Vegas, NV	Presenter
2019	Society of Family Planning, Los Angeles, CA	Presenter & Moderator
2020	Abortion Care Network, Louisville, KY	Presenter
2020	Center for Reproductive Rights Webinar	Presenter
2020	Abortion Care Network Webinar	Presenter
2020	National Abortion Federation	Presenter
2020	Mavericks Webinar	Presenter
2020	Society of Family Planning	Presenter
2020	Gynuity Annual Mifepristone Meeting	Presenter
2020	PPFA 6th Annual TeleMAB Stakeholders	Presenter
2020	NASEM Virtual Workshop on Family Planning, Women's Empowerment, And Population And Societal Impacts	Presenter
2020	Society of Family Planning, Online	Presenter
2021	Population Association of America, Online	Session Chair
2021	Population Association of America, Online	Session Chair
2021	National Abortion Federation	Presenter

INVITED PRESENTATIONS - REGIONAL AND OTHER INVITED PRESENTATIONS

2019	UCSF Bixby Abortion Seminar	Presenter
2020	UC Berkeley	Guest Lecturer
2020	ICAN Meeting on Self-Injection of DMPA-SC in Sub-Saharan Africa	Presenter
2020	UCLA Bixby Center on Population and Reproductive Health	Presenter
2020	ANSIRH Brown Bag	Presenter
2020	UCGHI Student Ambassadors Webinar	Presenter
2020	ANSIRH Brown Bag	Presenter
2020	WHGE COE Virtual Retreat	Presenter
2020	California Coalition for Reproductive Freedom (CCRF)	Presenter
2020	Bixby Center Virtual Webinar Series	Presenter
2020	California Abortion Alliance Webinar	Presenter

UNIVERSITY AND PUBLIC SERVICE

SERVICE ACTIVITIES SUMMARY

I have served in a leadership capacity within the UC System for over 5 years. Since 2016 I have been Director of Research of the UC Global Health Initiative (UCGHI) Center of Expertise in Women's Health, Gender, and Empowerment. Since 2020, I have also served on UCGHI's Black Lives Matter Taskforce. UCGHI is a 10-campus UC-wide initiative that stimulates, nurtures, and promotes global health research, education, and collaboration to advance the University's global health agenda.

My service activities to UCSF: Since 2012 I have served on UCSF RAP Review Committees. First I was on the mHealth Committee for 2 years and then in 2014 I joined the Career Development Review Committee, on which I still serve. This commitment involves serving on review committees, reviewing up to 3 grant proposals for 2 cycles/year.

UNIVERSITY SERVICE

UC SYSTEM AND MULTI-CAMPUS SERVICE

2010 - 2016	UC Global Health Initiative Center of Expertise in Women's Health and Empowerment	Member, Research Committee
2015 - 2016	UC Global Health Initiative Center of Expertise in Women's Health and Empowerment	Co-Chair, Knowledge Dissemination Committee
2016 - present	UC Global Health Initiative Center of Expertise in Women's Health, Gender, and Empowerment	Director of Research

UCSF CAMPUSWIDE

2012 - 2014	RAP mHealth Review Committee	Grant proposal reviewer
2014 - present	RAP Career Development Review Committee	Grant proposal reviewer
2016 - 2016	Parent Network Work Group	Work group member

SCHOOL OF MEDICINE

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DEPARTMENTAL SERVICE

2013 - 2013	Department of Obstetrics, Gynecology, & Reproductive Sciences, Research Retreat Committee	Member
2018 - present	Bixby Membership Committee	Member
2020 - 2020	BIRCWH K Award Proposal Reviewer	Reviewer

COMMUNITY AND PUBLIC SERVICE

1997 - 1998	SAKHI for South Asian Women, New York, NY (intimate partner violence organization)	Volunteer
2009 - 2009	MedShare International, San Francisco, CA	Volunteer
2005 - 2012	South Asian Women's Network (sawnet.org)	Moderator
2011 - 2014	Golden Gate Mothers Group, San Francisco, CA	Volunteer, Web Team
2015 - 2016	Golden Gate Mothers Group, San Francisco, CA	Chair, Web Team
2018 - 2019	Society of Family Planning, Denver, CO	Changemakers Ambassador

CONTRIBUTIONS TO DIVERSITY

CONTRIBUTIONS TO DIVERSITY

I am passionate about doing anti-racist work that I hope will improve equity within academia. Towards this end, I serve on the following UCSF committees:

- 1) In June 2020 I joined the University of California Global Health Institute's Black Lives Matters Taskforce (<https://ucghi.universityofcalifornia.edu/ucghi-black-lives-matter-task-force>). The Taskforce meets weekly and has developed an extensive work plan of activities that we will carry out over the coming year.
- 2) In 2019 I served on ANSIRH's DEI Faculty Hiring Group which led to the hiring of a faculty member this year in 2021.
- 3) I have also been working on an ANSIRH committee to develop a guidance document on Anti-Racist Practices for Academic Work. I currently also serve on a UCSF RAP grant review committee for underrepresented faculty in medicine.

I am committed to supporting the development of reproductive health scholars of color. I serve on the Society of Family Planning's Change Maker review committee, a dedicated effort is needed to actively support scholars of color focused on abortion and contraception. In this role, I help to identify and award grants to scholars of color who are beginning their academic careers in the field. Additionally, through individual mentoring, I have made substantial contributions to supporting diversity among the reproductive health academic community. I mentor several undergraduate and graduate students, most of whom identify as BIPOC. I bring a unique perspective to the mentoring relationship. I encourage and support the special needs and interests of women investigators who may face a variety of institutional and structural barriers.

As a woman of South Asian descent myself, who was raised primarily by a single mother who immigrated from Tanzania, I am drawn to reproductive autonomy, health, and well-being from a social justice perspective. My current work aims to understand how telehealth can be used to reduce barriers for immigrant and non-English speaking populations, and others excluded from health care. In my California Home Abortion by Telehealth (CHAT) Study, I developed a community advisory board early on composed of reproductive justice organizations. I also invited Ena Valladares, a researcher from California Latinas for Reproductive Justice, to be a

co-investigator to help ensure that those affected most by the research could contribute towards developing the research questions.

TEACHING AND MENTORING

TEACHING SUMMARY

Statistical and methodological consulting, mentoring, and guest lecturing form the core of my teaching activities. I spend an average of 5 hours per week providing statistical and methodological consultation to my advisees and colleagues. I also make myself available for statistical consulting to faculty and Fellows in the Department of Obstetrics, Gynecology and Reproductive Sciences and outside the University. Currently, I do not have formal teaching responsibilities in my department but I enthusiastically seek out opportunities to guest lecture courses on quantitative research methods and reproductive health. Since I joined UCSF in 2009, I have provided several lectures on contraceptive technology, measurement of women's empowerment, and contraception and abortion.

FORMAL TEACHING

Not UCSF	Academic Yr	Course No. & Title	Teaching Contribution	School	Class Size
	2009 - 2009	S248 Globalization and Global Health, UCSF	Lecturer; 1 lecture	Nursing	15
	2009 - 2009	Medication Abortion, UCSF	Lecturer; 1 lecture		20
	2009 - 2009	S289a Quantitative Research Methods, UCSF	Lecturer; 1 lecture	Nursing	20
	2011 - 2011	S289a Quantitative Research Methods, UCSF	Lecturer; 1 lecture	Nursing	20
	2013 - 2013	EPI 254: Social Epidemiology: Methods, Measures, and Concepts, UCSF	Lecturer; 1 lecture	Medicine	12
X	2013 - 2013	Women's Empowerment: Measurement, Meaning, and Making a Difference in Future Research, University of California, Berkeley	Lecturer; 1 lecture		20

Not UCSF	Academic Yr	Course No. & Title	Teaching Contribution	School	Class Size
	2015 - 2015	EPI 254: Social Epidemiology: Methods, Measures, and Concepts, UCSF	Lecturer; 1 lecture	Medicine	15
X	2015 - 2015	Education, empowerment, and fertility, University of California, Berkeley	Lecturer; 1 lecture		30
X	2017 - 2017	Gender and Global Health, Emory University, School of Public Health	Lecturer; 1 lecture		50
X	2020 - 2020	Survey Research Methods, Complex Family Planning Fellowship Research Course	Lecturer; 1 lecture		30

INFORMAL TEACHING

- 2008 - Reproductive Health, University of Michigan, Ann Arbor, MI
- 2011 - Advanced EndNote for Reproductive Research, San Francisco, CA
- 2012 - Women's Empowerment: Measurement, Meaning, and Making a Difference in Future Research, Seminar at Women's Health and Empowerment Retreat, Mill Valley, CA
- 2014 - Obstetrics, Gynecology & Reproductive Sciences Grand Rounds
- 2015 - "Incidence of emergency department visits and complications after abortion" Physicians for Reproductive Health Webinar (1 lecture)
- 2015 - "Gender-based power among adolescents and young women in the United States" Philip R. Lee Institute for Health Policy Studies (1 lecture)
- 2016 - "Women's Experiences with State-Level Abortion Restrictions in 5 States" Obstetrics, Gynecology & Reproductive Sciences Grand Rounds
- 2017 - State Regulation of Medication Abortion, EXPLAINED: Abortion Research & Policy Online Video Lectures

MENTORING SUMMARY

Statistical and methodological consulting, mentoring, and guest lecturing form the core of my teaching activities. I spend an average of 5 hours per week providing statistical and methodological consultation to my advisees. I also make myself available for statistical consulting to faculty and Fellows in the Department of Obstetrics, Gynecology and Reproductive Sciences and outside the University. Currently, I do not have formal teaching

responsibilities in my department but I enthusiastically seek out opportunities to guest lecture courses on quantitative research methods and reproductive health. I regularly give one or two guest lectures per year, teaching when invited by faculty colleagues.

PREDOCTORAL STUDENTS SUPERVISED OR MENTORED

Dates	Name	Program or School	Mentor Type	Role	Current Position
2009 - 2012	Rachel Goldstein	PACCTR Program, UCSF, Medical Student	Research/Scholarly Mentor, Project Mentor	Research Advisor	Clinical Assistant Professor
2013 - 2013	Roxanne Cu, RN, MSN	UCSF Global Health Clinical Scholar, NP Student	Research/Scholarly Mentor, Project Mentor	Research Advisor	Registered Nurse - San Francisco General Hospital
2011 - 2014	Deborah Karasek, MPH	UC Berkeley, Public Health	Career Mentor	Research Advisor	Assistant Professor, UCSF
2011 - present	Sheila Desai, MPH	Doctoral Student, City University of New York	Career Mentor	Statistical Advisor	Senior Research Associate, Guttmacher Institute
2013 - 2018	E. Angel James, CNM, WHNP-BC	UCSF School of Nursing Doctoral Student	Research/Scholarly Mentor, Project Mentor	Research Advisor	Staff Clinician, Family Planning Associates
2015 - present	Ann Fefferman	UC Irvine, Dept. of Sociology Doctoral Student	Research/Scholarly Mentor, Project Mentor, Career Mentor	Research Advisor and Dissertation Committee Member	Postbac Program, Tufts University
2016 - 2018	Natasha Mehta, MS	University of Illinois at Chicago Medical Student	Research/Scholarly Mentor, Project Mentor	Research Advisor	University of Illinois at Chicago Medical Student

Dates	Name	Program or School	Mentor Type	Role	Current Position
2017 - present	Iris Jovel	UCSF, Medical Student	Research/Scholarly Mentor, Project Mentor	Yearlong Inquiry Program Mentor	UCSF, Resident
2018 - present	Alice Cartwright, MPH	University of North Carolina, Gillings School of Global Public Health Doctoral Program	Research/Scholarly Mentor, Project Mentor, Career Mentor	Research Advisor	University of North Carolina Public Health Doctoral Student
2018 - present	Phoebe Danza, MPH	Keck School of Medicine of the University of Southern California	Research/Scholarly Mentor, Project Mentor	Research Advisor	Supervising Epidemiologist, LA County Department of Health
2019 - present	Ariana Bennett, MPH	UC Berkeley School of Public Health	Research/Scholarly Mentor, Project Mentor	Research Advisor	UC Berkeley School of Public Health Doctoral Student
2019 - present	Sarah Raifman, MS	UCSF Department of Epidemiology & Biostatistics Doctoral Program	Research/Scholarly Mentor, Project Mentor	Research Advisor	UCSF Epidemiology & Biostatistics Doctoral Student
2019 - present	Jackie Castellanos, MS	UC Berkeley-UCSF Joint Medical Program	Research/Scholarly Mentor, Project Mentor	Research Advisor	MD-MS Student at UC Berkeley-UCSF Joint Medical Program
2018 - present	Sarah Combellick, MPH	UC Davis Sociology Department	Research/Scholarly Mentor, Career Mentor	Research Advisor	UC Davis Sociology Doctoral Student

Dates	Name	Program or School	Mentor Type	Role	Current Position
2018 - present	Katherine McClendon, MS	UCSF School of Nursing	Project Mentor, Career Mentor	Research Advisor	UCSF School of Nursing Post Doctoral Student
2018 - present	Zahra Goliaei, MD, MPH	UC Merced Public Health Department	Research/Scholarly Mentor, Career Mentor	Research Advisor	UC Merced Public Health Post Doctoral Student
2019 - present	Chris Ahlback	UCSF Medical Student	Research/Scholarly Mentor	Yearlong Research mentor	UCSF Medical Student
2020 - present	Leah Koenig, MPH	UCSF Department of Epidemiology & Biostatistics Doctoral Program	Research/Scholarly Mentor, Project Mentor, Career Mentor	Research Advisor	UCSF Department of Epidemiology & Biostatistics Doctoral Program
2021 - present	May Nguyen	UCSF Medical Student	Research/Scholarly Mentor, Project Mentor	Deep Explore Project Mentor	UCSF Medical Student
2021 - present	Betsy Pleasants, MPH	UC Berkeley School of Public Health doctoral student	Research/Scholarly Mentor, Project Mentor, Career Mentor	Research Advisor	UC Berkeley School of Public Health

POSTDOCTORAL FELLOWS AND RESIDENTS MENTORED

Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
2011 - 2011	Nerys Benfield, MD	UCSF Clinical Fellow in Family Planning	Project Mentor	Research Advisor	Assistant Professor, Albert Einstein College of Medicine

Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
2012 - 2014	Chava Kahn, MD	University of Michigan Clinical Fellow in Family Planning	Research/Scholarly Mentor, Project Mentor	Statistical Advisor	Clinical Lecturer, Obstetrics & Gynecology
2012 - 2014	Elizabeth Uy-Smith, MD	UCSF SOM Primary Care Research Fellow	Project Mentor	Research Advisor	Associate Physician, UCSF School of Medicine, Family Community Medicine
2014 - 2018	Alison El Ayadi, ScD MPH	Assistant Researcher	Research/Scholarly Mentor, Career Mentor	Research Advisor	Assistant Professor
2014 - present	Nadia Diamond-Smith, PhD	Postdoctoral Fellow	Research/Scholarly Mentor, Career Mentor	Research Advisor	Assistant Professor
2019 - present	Stephanie Frazin, MD	UCSF Family Planning Research Fellow	Research/Scholarly Mentor, Career Mentor	Research Advisor	UCSF Family Planning Research Fellow
2019 - present	Elizabeth Harrington, MD	University of Washington Family Planning Fellow	Research/Scholarly Mentor, Career Mentor	Research Advisor	University of Washington Faculty and Family Planning Fellow
2020 - present	Mishka S. Peart, MD	University of North Carolina, Chapel Hill Family Planning Fellow	Research/Scholarly Mentor, Project Mentor	Research Advisor	University of North Carolina, Chapel Hill Family Planning Fellow

FACULTY MENTORING

Dates	Name	Position while Mentored	Mentor Type	Mentoring Role	Current Position
2014 - present	Nadia Diamond-Smith, PhD	Assistant Professor	Career Mentor	Career Mentor	Assistant Professor
2018 - present	May Sudhinaraset, PhD	Assistant and Associate Professor	Career Mentor	Career Mentor	Associate Professor

RESEARCH AND CREATIVE ACTIVITIES**RESEARCH AND CREATIVE ACTIVITIES SUMMARY**

I am Associate Professor at UCSF/ANSIRH. Over the last decade I have contributed substantially to what is known about abortion safety and access and reproductive empowerment measures. My work encompasses two themes: the effects of women's empowerment and gender equity on reproductive health and improving access to reproductive health services for historically excluded populations. My methodological expertise is in quantitative analyses using epidemiologic and demographic methods. I lead several projects related to contraception and abortion that collectively aim to expand women's ability to determine the number and timing of their children and improve access to reproductive health services. I have substantial experience analyzing large datasets, published articles in high-impact peer reviewed journals, and now have a track record securing independent funding for my research. I am a frequent cited authority on abortion safety, restrictions, and medication abortion and I have published op-eds in the New York Times, USA Today, and local news outlets to amplify the science of abortion. I am also Director of Research of UCGHI's Center of Expertise in Women's Health, Gender, and Empowerment and have established myself as a global expert in the measurement of women's reproductive empowerment.

My research focuses on the following areas:

1) Abortion safety. I published a seminal article on abortion safety using data from a closed system, California's state Medicaid program. This study demonstrated that less than 0.24% of abortions resulted in a major complication and was cited by Justice Ginsburg's concurring opinion in the Whole Woman's Health v. Hellerstedt Supreme Court case. It was also cited by a NYTimes Editorial on the Supreme Court Case, June v. McGee. I have also published national emergency department data that confirmed the California findings in a more generalizable dataset. In later years, I applied this expertise providing testimony in two cases contesting new state laws related to abortion complications reporting.

2) Impact of state-level restrictions. I led several studies evaluating the impact of state-level abortion restrictions, such as Wisconsin's mandatory ultrasound viewing law, Ohio's FDA protocol requirement for medication abortion, and admitting privileges laws in several states. My research has contributed to the evidence-base that these laws have minimal impact, or they harm rather than protect people seeking abortion. I led the Google Ads Abortion Access Study which used an innovative approach to recruiting and interviewing people considering an abortion but may never reach an abortion provider. I have published 3 papers from these data and several others are under review or in draft. These methods provided insight on how state

restrictions, including Medicaid bans, create barriers, prolong the search for abortion care, and offer no benefit in terms of decision certainty.

3) Expanding access to medication abortion. My research providing data on the need for medication abortion on California's campuses was pivotal to passing SB24, Student Right to Access Act. Additionally, I have been a ferocious advocate of demedicalizing medication abortion, co-authoring the No-Test Medication Abortion protocol, analyzing safety and efficacy outcomes of telehealth for abortion, and directly advocating with the FDA to remove the REMS. I have published several Op-Eds explaining the evidence-base for removing the REMS.

4) Increasing Open Access to Science. I lead ANSIRH's abortion facility database of publicly advertising abortion providers (<http://abortionfacilitydatabase.org/>). My contributions to science include leading an ANSIRH-wide committee to make this database available to external researchers. My research from these data documented that there are 27 abortion deserts, major cities from which people must travel over 100 miles to reach an abortion provider. By involving historically excluded student interns I have developed a pipeline for future social science abortion researchers.

5) Research on measurement of reproductive autonomy and empowerment. Another area of my work centers on measuring gender equity. Recognizing the absence of measures for U.S.-based research, I published the first-ever theory-based, validated standardized instrument to quantitatively measure the power to decide about and control matters related to contraceptive use, pregnancy, and childbearing—The Reproductive Autonomy Scale. With support from a Career Development Award from NICH/NICHD, I developed a sexual and reproductive empowerment scale for adolescents and young adults. This work has enabled other researchers to examine empowerment and reproductive outcomes. Additionally, I developed a database of gender and empowerment measures, hosted on ANSIRH's website.

RESEARCH AWARDS - CURRENT

1. N/A (gift)	Principal Investigator	Upadhyay (PI)
Individual Gifts	05/01/2020	09/30/2022
The California Home Abortion by Telehealth (CHAT Study)	\$ 500,000 direct/yr 1	\$ 800,000 total
The goal of this project is to test the safety and efficacy of a no-test telehealth model for medication abortion.		
2. A131550	Principal Investigator	Upadhyay (PI)
ANSIRH Core Funds	07/01/2020	06/30/2022
Abortion Facility Database	\$ 120,876 direct/yr 1	\$ 184,167 total
To develop and maintain a database of abortion providers throughout the United States.		
3. 7030632	Principal Investigator	Upadhyay (PI)
Tara Health Foundation	01/01/2020	12/31/2022
Proof of Concept: Using Misoprostol Alone for Menstrual Regulation	\$ 171,253 direct/yr 1	\$ 322,391 total

The major goal of this project is to assess if using misoprostol-alone for menstrual regulation is a feasible and acceptable.

4. 7500252 Principal Investigator Upadhyay (PI)
 CTSI RAP Award 01/01/2021 12/31/2021
 Proof of Concept: Using Misoprostol Alone for \$ 50,000 direct/yr 1 \$ 50,000 total
 Menstrual Regulation
 This funding supports clinic staff for the Proof of Concept Study on a Missed Period Pill

5. OPP121659 Co-Investigator Liu, Holt (PI)
 Bill and Melinda Gates Foundation 12/1/2019 12/31/2023
 Building the Evidence Base for Unlocking Demand \$ 1,713,103
 for Self-injection direct/yr 1
 The goal of the project is to understand how self-injection (SI) of DMPA-SC can be implemented to support informed contraceptive choice and use, from the perspective of women in Kenya, Malawi, Nigeria, and Uganda.

RESEARCH AWARDS - PAST

1. K01-HD042540 Doctoral Student Hindin (PI)
 Investigator
 NIH/NICHD 08/28/2002 06/30/2008
 Intergenerational Influences on Adolescent \$ 113,182 direct/yr
 Transitions 1
 To study the timing and predictors of demographic decisions of about 2,000 18-21 year old adolescents as they move toward adulthood among in the Cebu Longitudinal Health and Nutrition Survey. This award funds original data collection in the adolescents' cohabiting partners in 2002 and 2005 as well as expanded modules related to household decision-making and mental health in adolescents, their mothers, and their cohabiting partners.
2. No number assigned Principal Investigator/
 Consultant Upadhyay (PI)
 New York City Department of Health and Hygiene 09/01/2008 09/01/2009
 LDL Cholesterol Levels in New York City \$ 5,000 direct/yr 1 \$ 5,000 total
 NYC HANES is a community-based health survey modeled after the national NHANES, designed to obtain prevalence information for conditions which must be clinically diagnosed (eg. diabetes, cholesterol) for use by Department of Health programs and to better understand the burden of disease in New York City.
3. No number assigned Principal Investigator Upadhyay (PI)
 Demographic and Health Surveys, Macro 09/01/2009 12/31/2010
 International

Women's Empowerment and Ideal Fertility in Sub-Saharan Africa \$ 5,000 direct/yr 1 \$ 5,000 total

This fellowship funded research using data from 4 sub-Saharan African countries to determine whether various measures of women's empowerment are associated with a smaller ideal number of children.

4. 5R01-HD045480-05 Co-Investigator Raine Bennett (PI)
 NIH/NICHD 8/11/2004 5/31/2010
 Combined Hormonal Contraceptive Use in High Risk Women \$ 1,868,973 total

This study assesses contraceptive continuation and pregnancy rates among women using oral contraceptives, the patch, the vaginal ring, and DMPA among a group of young women at high risk of unintended pregnancy.

5. A116928 Principal Investigator Upadhyay (PI)
 UCSF Mount Zion Health Fund 02/11/2011 06/30/2012
 Estimating the Incidence and Associated Costs of Post-Abortion Complications from Medi-Cal Data \$ 30,000 direct/yr \$ 30,000 total
 1

Estimating the Incidence and Associated Costs of Post-Abortion Complications from Medi-Cal Data An analysis of Medi-Cal data to examine the costs associated with complications of abortion in California.

6. No number assigned Principal Investigator Upadhyay (PI)
 UCSF Center of Expertise, UC Global Health Institute 11/15/2010 11/15/2011
 Fellowship in Women's Health and Empowerment \$ 79,696 direct/yr \$ 79,696 total
 1

This Fellowship funds research and development of a reproductive empowerment index, including surveying family planning clients and psychometric evaluation of the results.

7. A107143 Co-Investigator Weitz (PI)
 Anonymous Private Foundation 06/01/2007 05/30/2014
 Access Through Primary Care Initiative \$ 3,500,000 total

This project seeks to examine abortion complication rates among properly trained nurse practitioners, certified nurse midwives and physician assistants offering early aspiration abortion compared to physicians.

8. P0053793 Principal Investigator Upadhyay (PI)
 Wellspring Advisors, LLC 12/1/2012 11/30/2014
 Addressing Abortion Stigma through Service Delivery \$ 64,195 direct/yr \$ 111,000 total
 1

This grant aims to develop a conceptual framework for understanding how service delivery reduces abortion stigma.

- | | | | |
|---|------------------------|--------------------------|-----------------|
| 9. A124380 | Principal Investigator | | |
| Mt. Zion Health Fund | | 11/01/2014 | 10/31/2015 |
| Interest in Self-Injection of DMPA-SC Among US Family Planning and Abortion Clients | | \$ 30,000 direct/yr
1 | \$ 30,000 total |
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- | | | | |
|---|------------------------|--------------------------|------------------|
| 10. P0053793 | Principal Investigator | | Upadhyay (PI) |
| Wellspring Advisors, LLC | | 12/1/2012 | 11/30/2014 |
| Addressing Abortion Stigma through Service Delivery | | \$ 64,195 direct/yr
1 | \$ 111,000 total |
- This grant aims to develop a conceptual framework for understanding how service delivery reduces abortion stigma.
-
- | | | | |
|---|------------------------|--------------------------|-----------------|
| 11. A123960 | Principal Investigator | | |
| Society of Family Planning | | 10/01/2014 | 9/30/2015 |
| Distance to an abortion provider and source of post-abortion care: Evidence from the Medi-Cal program | | \$ 93,169 direct/yr
1 | \$ 93,169 total |
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- | | | | |
|-------------------------------------|------------------------|---------------------------|--------------------|
| 12. A120961 | Principal Investigator | | Upadhyay (PI) |
| Anonymous Private Foundation | | 12/01/2012 | 11/30/2017 |
| Evaluation of Abortion Restrictions | | \$ 566,670 direct/yr
1 | \$ 3,228,308 total |
- This study documents the consequences of state-level abortion restrictions across the United States.
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- | | | | |
|--|------------------------|---------------------------|------------------|
| 13. A127836 | Principal Investigator | | Upadhyay (PI) |
| Society of Family Planning | | 10/01/2016 | 09/30/2017 |
| Emergency Department Visits and Major Complications After Abortion: Analysis of a Nationwide Emergency Department Sample | | \$ 109,091 direct/yr
1 | \$ 120,000 total |
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- | | | | |
|---|------------------------|------------|---------------|
| 14. No number assigned | Principal Investigator | | Upadhyay (PI) |
| National Center of Excellence in Women's Health | | 12/01/2016 | 11/30/2017 |

Using Google AdWords to Study Abortion Access: A Pilot Study		\$ 40,000 direct/yr 1	\$ 40,000 total
15.	Principal Investigator		Upadhyay (PI)
	UCSF Clinical & Translational Science Institute (CTSI)-Pilot Awards Program	01/01/2018	12/31/2018
	Development of the Sexual Health and Reproductive Empowerment for Young Adults (SHREYA) Scale	\$ 50,000 direct/yr 1	\$ 50,000 total
16. A127552	Principal Investigator		Upadhyay (PI)
	UCSF Clinical & Translational Science Institute (CTSI)-Pilot Awards Program	06/01/2018	05/31/2019
	Development of the Sexual Health and Reproductive Empowerment for Young Adults (SHREYA) Scale	\$ 50,000 direct/yr 1	\$ 50,000 total
17. 1K01HD077604	Principal Investigator		Upadhyay (PI)
	NIH/NICHD	10/1/2014	9/30/2019
	Effects of Gender-based Power on Contraceptive Use among Young People (K01)	\$ 144,586 direct/yr 1	\$ 693,324 total
18. A124803	Co-Investigator		Greene Foster, Rocca (PI)
	Anonymous Private Foundation	07/01/2015	06/30/2020
	Turnaway Study and Access to Abortion Study	\$ 1,328,862 direct/yr 1	\$ 8,567,472 total
19.	Principal Investigator		Upadhyay (PI)
	ANSIRH Core Funds	10/01/2018	03/31/2020
	Using Google AdWords to Study Abortion Access	\$ 90,680 direct/yr 1	\$ 171,401 total
20. Grant ID 5590	Principal Investigator		Upadhyay (PI)
	Anonymous Private Foundation	09/02/2019	06/30/2020

Post-Roe Strategies Project

\$ 291,330 direct/yr \$ 291,330 total

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PEER REVIEWED PUBLICATIONS

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39. Borrero S, Nguyen B, Sanders J, **Upadhyay UD**, White K. "It's her body:" Men's perspectives on their role in contraception and strategies for positive engagement. Oral presentation at the Society of Family Planning Annual Meeting. Los Angeles, CA. October 21, 2019.

OTHER CREATIVE ACTIVITIES

1. See family planning handbook (Zlidar, Upadhyay, and Lande) published in 2006 which provides technical guidance on the provision of contraceptive methods. Used to train medical students and health care providers within programs affiliated with the World Health Organization and the US Agency for International Development. Translated into 10 languages.

EXHIBIT 5

**IN THE DISTRICT COURT OF OKLAHOMA COUNTY
STATE OF OKLAHOMA**

OKLAHOMA CALL FOR REPRODUCTIVE JUSTICE, on behalf of itself and its members; TULSA WOMEN'S REPRODUCTIVE CLINIC, LLC, on behalf of itself, its physicians, its staff, and its patients; ALAN BRAID, M.D., on behalf of himself and his patients; COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, INC., on behalf of itself, its physicians, its staff, and its patients; and PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, on behalf of itself, its physicians, its staff, and its patients,

Plaintiffs,

v.

JOHN O'CONNOR, in his official capacity as Attorney General for the State of Oklahoma; DAVID PRATER, in his official capacity as District Attorney for Oklahoma County; STEVE KUNZWEILER, in his official capacity as District Attorney for Tulsa County; LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; KATIE TEMPLETON, in her official capacity as President of the Oklahoma State Board of Osteopathic Examiners; LANCE FRYE, in his official capacity as the Commissioner of the Oklahoma State Board of Health; and JUSTIN WILSON, in his official capacity as the President of the Oklahoma State Board of Pharmacy; as well as their employees, agents, and successors,

Defendants.

CASE NO. _____

**AFFIDAVIT OF JOEY BANKS, M.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR
TEMPORARY INJUNCTION**

Dr. Joey Banks declares and states the following:

1. I am a board-certified family medicine physician. I provide abortion care, including medication abortion and procedural abortion up to 18 weeks LMP, at Tulsa Women's Reproductive Clinic ("Tulsa Women's"), a Plaintiff in this case. Since 2012, I have also provided care at Blue Mountain, an independent primary and family medicine clinic in Missoula, Montana, where I was Reproductive Health Medical Director for some time. For nine of my years at Blue Mountain, I served as a community preceptor, teaching abortion care to a variety of doctors, including family medicine residents and medical students. Since 2019, I have also provided reproductive healthcare at Planned Parenthood of Montana, where I formerly served as Chief Medical Officer. In earlier parts of my career, prior to 2012, I worked for the Alaska Native Health System practicing family medicine and obstetrical delivery. From 2009 to 2010, I served as the Medical Director of Planned Parenthood Alaska, where I supervised medical staff at two clinics in the state. I also served as faculty for Central Maine Medical Center and Alaska Family Practice residencies teaching residents family medicine, obstetrics, and reproductive care.

2. I am board-certified as a family medicine physician by the American Board of Family Medicine. I received my M.D. from Indiana University School of Medicine and completed my residency in family medicine at the Alaska Family Medicine Residency in Anchorage, Alaska, where I also served as chief resident.

3. During my family medicine residency, I was trained in family medicine, obstetrics, and reproductive care. This included a rotation during which I observed abortion procedures at a local clinic.

4. I have been a practicing family medicine physician for over 20 years, with extensive experience providing the full range of reproductive healthcare, particularly in rural settings, including abortion care, gynecological care, vasectomies, and labor and delivery care.

While I now specialize in abortion care, I still provide a range of reproductive healthcare, including cancer screenings, endometrial and cervical biopsies, testing and treatment for sexually transmitted infections, contraceptive implant insertions and removals, colposcopy, LEEP, ultrasound, ectopic medical care, and miscarriage management. I keep my board certification and continuing education up to date for my family medicine specialty.

5. I am currently licensed to practice medicine in Montana, Oklahoma, and Idaho. I have inactive licenses in Maine and Alaska.

6. I was born and raised in Tulsa, Oklahoma. I have provided care around the country for over twenty years and practiced here in Oklahoma for almost three years.

7. Over the course of my clinical career, I have worked closely with a wide array of clinicians who provide high quality abortion care consistent with their training, including OB/GYNs, emergency room physicians, anesthesiologists, and family medicine physicians. I am also familiar with and have trained advanced practice clinicians (“APCs”) who are competent to provide medication abortion and early procedural abortion.

8. I have received grants from Reproductive Health Education in Family Medicine (“RHEDI”) to teach family medicine clinicians and residents abortion and miscarriage management at both Central Maine Medical Center and Family Medicine Residency of Western Montana. RHEDI has developed a leading evidence-based curriculum for teaching abortion to family medicine clinicians and residents. I also work with Training in Early Abortion for Comprehensive Healthcare (“TEACH”), Reproductive Health Access Project (“RHAP”), and I am a member of the American Academy of Family Physicians (“AAFP”), the Society of Family Planning (“SFP”), and the American College of Obstetricians and Gynecologists (“ACOG”).

9. A current version of my curriculum vitae, which sets out my experience and credentials more fully, is attached to this declaration as Exhibit A.

10. The opinions in this affidavit are based on my education, training, clinical and teaching experience, research, ongoing review of professional literature, and attendance at professional conferences.

H.B. 1904 (the “OB/GYN” Requirement) serves no medical purpose and will drastically restrict abortion access in Oklahoma.

11. I understand that one of the laws challenged in this case, the OB/GYN requirement, requires physicians providing abortion in Oklahoma to be board-certified in obstetrics and gynecology. I understand that a violation of this law is a felony, punishable by one to three years in prison.

12. In my opinion, this requirement has no medical basis and will significantly reduce the number of providers, and thus access to abortion, in Oklahoma.

13. Three physicians who provide abortion care at Tulsa Women’s are board-certified family medicine physicians, including myself. We make up half of the physicians who provide abortion care at the clinic. At Tulsa Women’s, I am also one of three physicians who regularly provides procedural abortions up to 18 weeks LMP. One of the other physicians at Tulsa Women’s who provides procedural abortions up to this stage in pregnancy is also a family medicine physician. H.B. 1904 will thus disqualify three highly trained physicians at Tulsa Women’s who provide the majority of procedural abortions, as well as other doctors in the state who are not board-certified in obstetrics and gynecology.

Experience and training—not specialty—determines competence to provide abortion care.

14. Based on my years of experience providing abortion care, working with other abortion providers, and training other clinicians to provide abortion care, it is my opinion that

specialty is not determinative of whether a clinician will be competent to provide abortion care. Proper training and experience is.

15. The training I received and provide to other clinicians includes multiple components. I train clinicians in all aspects of procedural abortion and the medication abortion regimen. My training involves lecturing, observation, and one-on-one practical teaching at sites. I have trained approximately 150 clinicians, and I have trained clinicians all over the country, including in a diverse range of settings. Though complications are rare, I teach trainees how to recognize and handle even very rare complications, whether that means treating the patient themselves or referring them to specialists or emergency care if necessary. Critically, I provide training in patient counseling—counseling around abortion requires patient-centered care, respect, compassion, and non-judgmental communication. It is essential in abortion care to facilitate the patient in making the decision that is right for them, their health, and their families.

16. In my extensive experience providing and teaching abortion care, a range of physicians across specialties can become skilled abortion providers. It is also well-established that APCs can provide early abortion as safely and effectively as physicians.¹

17. There is no special element of the OB/GYN residency that makes OB/GYNs any more qualified to provide—or learn how to provide—abortion than physicians with other specialties, such as family medicine. OB/GYNs are not required to train in abortion care. In my

¹ Tracy A. Weitz, et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician-Assistants Under a California Legal Waiver*, 103.3 Am. J. Pub. Health 454-61 (2013), <https://ajph.aphapublications.org/doi/10.2105/AJPH.2012.301159>; ACOG, Comm. on Health Care for Underserved Women, *Committee Opinion No. 815, Increasing Access to Abortion* 136(6) Obstetrics & Gynecology e107-15 (Dec. 2020) (replaces Committee Opinion No. 613, Nov. 2014) (“ACOG Comm. Op. 815”), <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2020/12/increasing-access-to-abortion.pdf>.

professional experience, I have encountered many OB/GYNs who do not provide abortion. One survey of residency program directors found that “only 51% of obstetrics and gynecology residency programs offered routine abortion training.”² Medical training programs have routinely reached out to me, a family medicine specialist, to be an educator and train students, residents (including OB/GYN residents), and fellows in the provision of abortion care.

18. For these reasons, ACOG characterizes requirements that “clinicians who provide abortion must be board certified obstetrician-gynecologists” as “medically unnecessary requirements designed to reduce access to abortion” because “clinicians in many medical specialties can provide safe abortion services.”³

19. ACOG has also repeatedly reaffirmed that “[s]afe, legal abortion is a necessary component of comprehensive health care.”⁴ Consistent with this, ACOG recommends expanding “[t]he pool of clinicians who provide first-trimester medication and aspiration abortion to appropriately trained and credentialed advanced-practice clinicians in accordance with individual state licensing requirements.”⁵

20. Indeed, in my experience providing abortion training, I have not found any difference in the abilities of OB/GYNs and family medicine doctors in their ability to become highly skilled abortion providers.

Family practice physicians are trained in holistic medical care, which is highly compatible with providing high quality abortion care.

² ACOG, Comm. on Health Care for Underserved Women, *Committee Opinion 612, Abortion Training and Education*, 124(5) *Obstetrics & Gynecology* 1055-59 (Nov. 2014, reaff’d 2017) (“ACOG Comm. Op. 612”), <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2014/11/abortion-training-and-education.pdf>.

³ ACOG Comm. Op. 815.

⁴ *Id.*

⁵ *Id.*

21. To become board-certified in family medicine, one must apply to, be accepted by, and complete a three-year family medicine residency program, which includes rotations in various specialties. A physician must then prepare for and pass a board exam. To obtain board-certification in a new specialty, such as OB/GYN, a physician would have to repeat this entire process—including applying to, being accepted by, and completing another multi-year residency program and then preparing for and passing another board exam.

22. Family medicine doctors are often uniquely positioned to be competent abortion providers. The family medicine specialty is directed at treating the whole person—from pediatrics through elder care. Many family medicine physicians provide primary care to whole families. The goal is continuity and holistic care—our training enables us to see the big picture of what is happening in a patient’s life and health. In service of this goal, family medicine residencies place an emphasis on counseling and patient interaction.

23. The scope of practice for family medicine physicians can include a large array of procedures in which individual physicians may achieve competency through training and experience. Some of these procedures are comparable to or riskier than abortion. For example, some family medicine physicians learn to perform colonoscopies or vasectomies. Others provide obstetrical care including prenatal care and delivery, as I did early in my career, and childbirth is far riskier than abortion.⁶ Many family medicine doctors manage miscarriages, which involves the same procedures and technical skills as abortion care.⁷

⁶ Elizabeth Raymond & David Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2 pt. 1) *Obstetrics & Gynecology* 215-19 (2012), <https://pubmed.ncbi.nlm.nih.gov/22270271/>.

⁷ Linda W. Prine and Honor MacNaughton, *Office Management of Early Pregnancy Loss*, 84(1) *Am. Fam. Physician* 75 (2011), <https://www.aafp.org/afp/2011/0701/afp20110701p75.pdf>.

24. The scope of practice for family medicine physicians can also include the use of a range of prescription drugs. For example, family medicine physicians routinely prescribe medications that are comparable to or riskier than medication abortion, such as antibiotics or pain medications like fentanyl. And, as mentioned above, many family medicine doctors (as well as various other types of clinicians) provide miscarriage management.⁸ Managing a miscarriage by medication is typically identical to the medication abortion regimen.⁹

25. Though complications from abortion are rare, family medicine physicians are competent to manage and treat complications that arise from both procedural and medication abortion. Like clinicians in many other specialties, including OB/GYN, family medicine physicians are also competent to determine the need for a referral if the patient develops a health condition that they are unable to treat.

26. Indeed, the National Academies of Sciences, Engineering, and Medicine reviewed studies of the safety of abortion care as conducted by family medicine practitioners and found that “[a]ll complications were minor and managed effectively at rates similar to those in OB/GYN practices and specialty abortion clinics.”¹⁰ The report concluded that family medicine practitioners could provide safe and effective procedural and medication abortion care.

There is a dearth of abortion providers and training in the United States and disqualifying competent clinicians harms patients.

27. I do not live in Oklahoma, but travel to the state to provide abortion care. I also provide at multiple clinics across Montana. The primary reason I travel to clinics to provide care

⁸ *Id.*

⁹ Courtney A. Schreiber, et al., *Mifepristone Pretreatment for the Medical Management of Early Pregnancy Loss* 378(23) New Eng. J. Med. 2161 (2018), <https://www.nejm.org/doi/pdf/10.1056/NEJMoal715726>.

¹⁰ Nat’l Acads. Of Scis., Eng’g., & Med. *The Safety and Quality of Abortion Care in the United States*, at 105 (2018), <http://nap.edu/24950>.

is because of the need for abortion providers in these rural states. Like me, many of my colleagues at Tulsa Women's and in Montana also travel to provide care.

28. There is shortage of abortion providers in many parts of the United States, and few institutions are committed to providing training in abortion care. Clinicians often have to seek out sufficient training in abortion care because there is either no training or too little training in their education programs. Concentrated programs have tried to fill the gap—including the RHEDI program which provides and supports abortion and miscarriage training in family medicine residencies.¹¹ As mentioned above, I have taught at the RHEDI program at both Central Maine Medical Center and Family Medicine Residency of Western Montana—providing both preceptor lectures and one-on-one practical teaching in clinic. Indeed, programs like these recognize that family medicine physicians, “given their broad scope and diverse geographic practice regions,” are particularly “well positioned to increase abortion access” in “abortion deserts.”¹² Unfortunately, despite these programs, the supply of providers continues to fall short of the need.¹³ This is particularly true in the rural areas where I practice. For example, to my knowledge, I am one of only a few physicians in Montana who publicly provides dilation and evacuation (“D&E”), the most common method of abortion after approximately 14-15 weeks LMP. And at Tulsa Women's, as mentioned above, I am one of only three physicians who regularly provides procedural abortions up to 18 weeks LMP. All of this underscores that there is

¹¹ The Ctr. For Reprod. Health Educ. In Family Med., *What We Offer*, <https://rhedi.org/about/what-we-offer/> (last visited Aug. 26, 2021).

¹² Payal Patel, et al., *Abortion Provision Among Recently Graduated Family Physicians* 52(10) Fam. Med. 724-29, <https://journals.stfm.org/familymedicine/2020/november-december/paul-2020-0190/>.

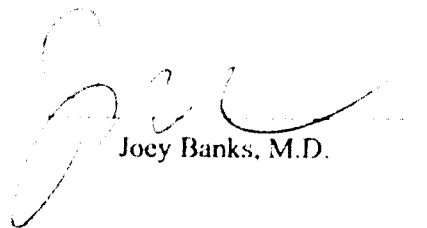
¹³ ACOG Comm. Op. 612.

no medical reason to require abortion providers to be board-certified OB/GYNs, unless the intent is to immediately prevent a large percentage of qualified clinicians from providing abortion care.

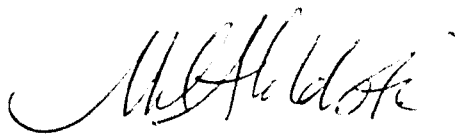
29. Hiring physicians to provide abortion is always challenging, given the immense stigma around abortion, particularly in Oklahoma. Replacing three doctors at Tulsa Women's simultaneously would be particularly challenging, if it were possible at all, especially if they all had to be board-certified OB/GYNs. When I have hired clinicians to provide abortion, I didn't look to their specialty—I looked for their experience and training.

30. Oklahoma should not tie the hands of highly skilled providers. Doing so will dramatically restrict access to abortion and thus harm Oklahomans who need access to essential abortion care.

Dated: August 30, 2021


Joey Banks, M.D.

NOTARY



MELANIE A. GOLDSTEIN
Notary Public, Maine
My Commission Expires December 5, 2024



EXHIBIT A

Joey Banks, MD ABFM (she/her)
406-240-9440
Joeydavidmaine@hotmail.com

Employment

Oct 2021 to June 1, 2021 University of Montana Genomics Core Lab
Laboratory Director- High Complexity Lab
Emergent Covid- 19 testing site for Montana

- Provided QA and QI for lab
- Supervised testing and staff

Jan 23, 2019, to current Planned Parenthood of Montana
Chief Medical Officer
Missoula Montana

April 2021 became interim medical director only

July 10th, 2021 became only contract doctor for abortion care only, Principal Investigator for Gynuity research, Moderate Complex Lab director, physician consult for US cases and as needed for other cases.

- Staff physician- primary care and abortion
- Supervise medical staff at all statewide sites (MD, ANP, PA, RN, LPN, CA)
- Lab director Moderate Complex Lab for 5 sites. Trains and hires personnel. Provides quality assurance. Develops policy and protocol for new tests PPMT uses.
- Ensure guidelines and standard protocols are fulfilled per PP Medical Standard and Guidelines.
- Staff Clinician
- New project supervision
- PI Gynuity Research project
- PA staff supervisor
- Train residents and students
- Hire and train contract physicians
- Serve as senior leadership for PPMT and work with team to help with state-wide initiatives

July 2012- March 2019 Blue Mountain Clinic
Reproductive Health Medical Director
Missoula Montana

- Staff physician- primary care
- Community preceptor for Family Medicine Residency Western Montana
- Gender affirming care hormone therapy including youth care and blockers
- Youth gender affirming care community organizer/lecturer
- Western Montana Family Medicine Resident Community Attending- award for best community attending in 2014/2020
- Awarded RHAP Miscarriage Care Initiative Grant for WMFMR and our clinic
- Assisted in RHEDI grant application and implementation
- Partnered with OAA as medical supervisor for GC/CT program testing and treatment
- LEEP, vasectomy, cryo-therapy, skin lesions, primary care, reproductive care, aspiration abortion to 18 weeks EGA, medical abortion, Accutane
- Assisted in Lab Management with lab director to hire and train personnel and to provide quality assurance and training for moderate complex lab.

February 2010- July 2012 Arusha Lutheran Medical Center
Arusha Tanzania
Family Physician

- Outpatient clinic volunteer and school-based clinic/educator
- Grounds for Health volunteer for VIA training
- Prenatal, gynecology, pediatrics, family medicine
- **Sexual Abuse and Rape Care Committee chair**
 - ✓ Wrote medical policy, training program, and curriculum
- ALSO- Advanced Life Saving Obstetrics instructor
 - ✓ Modified curriculum for African medical care and policies

2007-December 2009

Lewiston ME

Central Maine Medical Center Family Medicine Residency

Family Physician Faculty- Inpatient/Outpatient/Obstetrics

- Faculty
- Curriculum Committee Chair
- Gynecology Curriculum Coordinator
- **RHEDI grant coordinator-** IPAS MVA abortion, miscarriage, and ultrasound training director (200,000\$ grant)- wrote curriculum, policy and initiated

2008-December 2009

Portland ME

Planned Parenthood NNE

Contract Physician

- Colpo, Cryo, miscarriage care, LEEP, fetal demise and abortion care, family planning

2005-2007

Anchorage AK

Planned Parenthood of Alaska

Medical Director for State of AK (2 clinics)

- Supervised medical staff at 4 clinics (MD, ANP, RN, LPN, RHS)
- Colposcopy, LEEP, vasectomy, Implanon master trainer, family practice, abortion, and gynecology health service clinician
- Assisted in writing Men's Reproductive Health Protocol for medical care for National Planned Parenthood of America
- Worked with Patient Service Director on drug formularies, lab manuals, education issues for staff, coding and billing.
- Helped with statewide education, public policy, and fundraising issues
- Lab Director for 2 sties. Moderate Complexity. Helped to establish moderate complex lab and develop policy and protocols for the lab. Hired personnel and trained staff on testing. Maintained quality assurance for the lab.

2005-2007

Anchorage AK

Providence Family Medicine Residency

Faculty and Gynecology/Elective/Evaluation Coordinator

- Supervised residents in clinic and inpatient care for pediatric, obstetrical, and medical admissions.
- Developed curriculum for gynecology rotations for the residents
- " Faculty of the Year Award"- for 2006 (voted by residents)
- Managed panel of patients and did clinic outpatient visits
- Faculty for 2005-2006, then volunteer faculty 2006-2007

2001-2005

Anchorage AK

ANMC-Primary Care Center

Family Practice Clinician

- Medical Student Supervisor through University of Washington
- Secretary Medical Staff ANMC 2002-2003
- PCC liaison for women's health and obstetrical care
- Village MD for Sandpoint AK (pop 3000)
- Team physician for panel of approximately 1400 patients
- Family practice care including prenatal and obstetrics
- Member of Quality Assurance PCC committee

1998-2001

Anchorage AK

Alaska Family Practice Residency

Providence Family Practice Resident

- Chief Resident
- Third Year Resident Teacher of Year (2001) and Intern of the Year (1998)
- AAFP National Resident Rural Committee representative 2000

2001-2003

Seward AK

Providence Seward ER

ED Locum Physician

Contract Doctor Employment Positions:

February 2021 to current **Tulsa Women's Clinic**
Tulsa, Oklahoma

- Medical abortion, surgical abortion first and second trimester, IV sedation provider, Ultrasound provider

April 2021 to current **Planned Parenthood of Montana**
Billings, Missoula, Helena Montana

- Medical abortion, surgical abortion first and second trimester, IV sedation provider, Ultrasound provider, Abortion trainer for other physicians or residents

March 2019 to current **Blue Mountain Clinic Family Medicine**
Missoula Montana

- Medical abortion, surgical abortion first and second trimester, IV sedation provider, Ultrasound provider, Abortion trainer for other physicians or residents

Dec 2019 to March 2020 **Trust Women**
Oklahoma City, Oklahoma

- Medical abortion, surgical abortion first and second trimester, IV sedation provider, Ultrasound provider

Education

- 1998-2001 Alaska Family Medicine Residency
- 1994-1998 Indiana University School of Medicine
- 1986-1989 Baylor University- BA Sociology

Certifications

- Board Certification Family Medicine current
- State of Alaska, Maine Physician License previous
- State of Montana, Oklahoma, Idaho Physician License current
- DEA current
- COLA Lab Director Certification- Lab Director course completion
- ACLS current

Other/Lectures and Associations

- Contraception Update Lecturer for AAFP AK and AK PA association
- Speaker for MT AAFP meetings/statewide hospital CME (contraception update, miscarriage care, care, gender dysphoria)
- Co- Author Gynuity Research articles 2021
- Community Preceptor for WMFMR
- Ultrasound training for basic gynecology and prenatal care Lecturer STFM
- Member of AAFP, RHAP, SFP, ACOG, MT AAFP
- Peace Corps Volunteer Ghana West Africa- teacher (1990-1993)
- Merck Nexplanon master trainer 2006- current
- Residency International Experience Cameroon
- Medical School International Experience Kenya