Approved, SCAO

Original - Court
1st copy - Defendant

2nd copy - Plaintiff
3rd copy - Return

STATE OF MICHIGAN Court of Claims JUDICIAL DISTRICT JUDICIAL CIRCUIT COUNTY	SUMMONS	CASE NO.

Court address

Hall of Justice, 925 W. Ottawa St., P.O. Box 30185, Lansing, MI 48909

Court telephone no.

(517) 373-0807

Plaintiff's name, address, and telephone no.		Defendant's name, address, and telephone no.
Northland Family Planning Center, Northland Family Planning Center Inc. East, Northland Family Planning Center Inc. West, and Medical Students for Choice	v	Dana Nessel, Attorney General of the State of Michigan Department of Attorney General 525 W Ottawa St Lansing, MI 48933 (517) 335-7622
Plaintiff's attorney, bar no., address, and telephone no. David A. Moran, MI Bar #P45353, 701 S. State Street Ann Arbor, MI 48109, (734) 615-5419		

Instructions: Check the items below that apply to you and provide any required information. Submit this form to the court clerk along with your complaint and, if necessary, a case inventory addendum (MC 21). The summons section will be completed by the court clerk.

Domestic Relations Case

☐ There are no pending or resolved cases within the jurisdiction of the family division of the circuit court involving the family or family members of the person(s) who are the subject of the complaint.

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Civil Case

☐ This is a business case in which all or part of the action includes a business or commercial dispute under MCL 600.8035.

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Summons section completed by court clerk.

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Summons (3/23) **Case No.** _____

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☐ I am a legally competent adult who is not a party or an officer of a corporate party. I declare under the penalties of perjury that this certificate of service has been examined by me and that its contents are true to the best of my information, knowledge, and belief.

Service fee	Miles traveled	Fee	
$		$	
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Signature

_____
Name (type or print)

MCL 600.1910, MCR 2.104, MCR 2.105

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Court address

Hall of Justice, 925 W. Ottawa St., P.O. Box 30185, Lansing, MI 48909

Court telephone no.

(517) 373-0807

Plaintiff's name, address, and telephone no.		Defendant's name, address, and telephone no.
Northland Family Planning Center, Northland Family Planning Center Inc. East, Northland Family Planning Center Inc. West, and Medical Students for Choice	v	Marlon I. Brown, Acting Director Michigan Department of Licensing and Regulatory Affairs Ottawa Building 611 W. Ottawa Lansing, MI 48909 (517) 241-7124
Plaintiff's attorney, bar no., address, and telephone no. David A. Moran, MI Bar #P45353, 701 S. State Street Ann Arbor, MI 48109, (734) 615-5419		

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Plaintiff's name, address, and telephone no.		Defendant's name, address, and telephone no.
Northland Family Planning Center, Northland Family Planning Center Inc. East, Northland Family Planning Center Inc. West, and Medical Students for Choice	v	Elizabeth Hertel, Director Michigan Department of Health and Human Services 333 S. Grand Ave Lansing, Michigan 48909 (517) 241-3740
Plaintiff's attorney, bar no., address, and telephone no. David A. Moran, MI Bar #P45353, 701 S. State Street Ann Arbor, MI 48109, (734) 615-5419		

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Name (type or print)

MCL 600.1910, MCR 2.104, MCR 2.105

STATE OF MICHIGAN
IN THE COURT OF CLAIMS

NORTHLAND FAMILY PLANNING CENTER, on behalf of itself, its staff, its clinicians, and its patients; **NORTHLAND FAMILY PLANNING CENTER INC. EAST**, on behalf of itself, its staff, its clinicians, and its patients; **NORTHLAND FAMILY PLANNING CENTER INC. WEST**, on behalf of itself, its staff, its clinicians, and its patients; and **MEDICAL STUDENTS FOR CHOICE**, on behalf of itself, its members, and its members' patients,

Plaintiffs,
v.

DANA NESSEL, Attorney General of the State of Michigan; **MARLON I. BROWN**, Acting Director of Michigan Licensing and Regulatory Affairs; and **ELIZABETH HERTEL**, Director of the Michigan Department of Health and Human Services, each in their official capacities, as well as their employees, agents, and successors,

Defendants.

Case No.

Hon.

This case involves a claim that a statute is unconstitutional.

VERIFIED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

Rabia Muqaddam, NY Bar #5319413*
rmuqaddam@reprorights.org
Alexandra Willingham, NY Bar #5851712*
awillingham@reprorights.org
Center for Reproductive Rights
199 Water Street, 22nd Floor
New York, NY 10038
(917) 637-3645 Phone
(917) 637-3666 Fax

David A. Moran, MI Bar #P45353
Morand@umich.edu
701 S. State Street
Ann Arbor, MI 48109
(734) 615-5419 Phone

ATTORNEYS FOR PLAINTIFFS

*Pro Hac Vice Application Forthcoming

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Orrick, Herrington & Sutcliffe LLP
1000 Marsh Road
Menlo Park, CA 94025
(650) 614-7400

Meghan Kelly*
Orrick, Herrington & Sutcliffe LLP
51 West 52nd Street
New York, NY 10019
(212) 506-5000

VERIFIED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

There is no other civil action between these parties arising out of the same transaction or occurrence as alleged in this complaint pending in this court, nor has such action been previously filed and dismissed or transferred after having been assigned to a judge, nor do I know of any other civil action, now between these parties, arising out of the same transaction or occurrence as alleged in this complaint that is either pending or was previously filed and dismissed, transferred, or otherwise disposed of after having been assigned to a judge in this court.

/s/ David A. Moran
David A. Moran
MI Bar #P45353

Plaintiffs Northland Family Planning Center, Northland Family Planning Center Inc. East, and Northland Family Planning Center Inc. West (collectively, "Northland"), each on behalf of itself, its clinicians, its staff, and its patients, and Medical Students for Choice ("MSFC"), on behalf of itself, its members, and its members' patients, by and through their undersigned attorneys, bring this Complaint for declaratory and injunctive relief against the above-named Defendants, their employees, agents, and successors in office and in support thereof state the following:

I. PRELIMINARY STATEMENT

1. Michiganders have a fundamental right to abortion guaranteed by their state constitution. Pursuant to this right, Michiganders seeking abortion must be free from medically unjustified laws denying, burdening, or infringing their decision to have an abortion. Further, Michiganders must be free of discrimination in the enforcement or protection of this constitutional right. In this case, abortion providers and advocates challenge three abortion restrictions that run roughshod over these constitutional guarantees.

2. On November 8, 2022, following the United States Supreme Court's decision to reverse 50 years of precedent protecting a federal right to abortion, the people of Michigan voted to enact the Reproductive Freedom For All Amendment (the "RFFA"). Const 1963, art I, § 28. The RFFA amended the Michigan Constitution to protect an individual's "fundamental right to reproductive freedom," including an individual's decision about whether to have an abortion, subject to strict scrutiny. *Id.* § 28(1). As a result, Michigan cannot enact laws that "den[y], burde[n]," or "infringe[]" the individual's right to abortion without demonstrating that such laws serve a compelling interest achieved by the least restrictive means. *Id.* The *only* compelling interest the State can assert under the RFFA is the "limited purpose of protecting the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine." *Id.* § 28(4). The RFFA explicitly dictates that the State can *never* advance a compelling state interest in patient health via means that intrude "on [an] individual's autonomous decision-making." *Id.*

3. In addition to this substantive fundamental liberty, the RFFA also explicitly prohibits "discriminat[ion] in the protection or enforcement of this fundamental right," § 28(2), such that restrictions on reproductive freedom cannot stand if they privilege some reproductive choices over others, including by subjecting abortion to unique restrictions not applicable to other pregnancy care. Restrictions on abortion also cannot disproportionately harm certain groups, such as Black, indigenous, and other people of color. This nondiscrimination clause is broad on its face. Consistent with Michigan's civil rights traditions, discrimination on the basis of religion, race, color, national origin, age, sex, sexual orientation, gender identity or expression, height, weight, familial status, or marital status is impermissible under the RFFA's nondiscrimination clause.

4. This action for declaratory and injunctive relief challenges the constitutionality of three Michigan abortion restrictions that provide no health benefit whatsoever, undermine the standard of care, and interfere with patients' autonomous decision-making—the 24-Hour Delay, Mandatory Biased Counseling, and Provider Ban (collectively the "Challenged Laws"), set forth at MCL 333.17015 (attached hereto as Exhibit A) and 333.17015a (attached hereto as Exhibit B).

5. The 24-Hour Delay and Mandatory Biased Counseling were designed to pressure Michiganders into choosing continuing a pregnancy over abortion. They force patients to needlessly delay time-sensitive abortion care and impose logistical barriers. They also force patients to consume uniform information encouraging them to continue a pregnancy—much of which is irrelevant, misleading, and/or stigmatizing—regardless of their individual needs and circumstances. As a result, the 24-Hour Delay and Mandatory Biased Counseling actually *thwart* true informed consent and autonomous healthcare decision-making, which are inherently individualized and centered around a patient's autonomy.

6. For the same reasons, these laws are contrary to the standard of care. These requirements plainly violate Michiganders' right to abortion because they lack any medical justification, are inconsistent "with accepted clinical standards of practice and evidence-based medicine," and *intentionally* interfere with an "individual's autonomous decision-making." Const 1963, art 1 § 28(4). These requirements also perpetuate the false idea that pregnant Michiganders need the State's paternalistic intervention. Michiganders have now stated through the RFFA, in the most forthright terms, that they do not need the State to help them decide what healthcare is best for them. They do not need to consume boiler-plate ideological materials or experience a forced delay in order to make their own healthcare decisions.

7. The Provider Ban, which prohibits anyone other than a physician from providing abortions, is similarly a clear violation of the individual's fundamental right to abortion. Robust research and provider experience in numerous states demonstrates that Advanced Practice Clinicians ("APCs") like Certified Nurse Midwives ("CNMs"), Nurse Practitioners ("NPs"), and Physician Assistants/Associates ("PAs") provide abortion care in early pregnancy as safely and effectively as physicians. Excluding them from providing this care serves no one, and it restricts the availability of this essential and constitutionally protected healthcare for patients. As a result, the Provider Ban also infringes Michiganders' ability to choose abortion without medical justification, is inconsistent with the standard of care, and burdens patients' decision-making by restricting access to clinicians. Michiganders are constitutionally entitled to have access to abortion that is not limited by useless restrictions on qualified clinicians.

8. For all of these reasons, all mainstream medical professional institutions that have weighed in on the provision of abortion care in the United States have concluded that laws like those challenged here—mandatory waiting periods, biased counseling provisions, and provider restrictions—have no medical basis, are out of line with the standard of care, and intrude on autonomous decision-making, thereby significantly harming patients. For example, in its comprehensive report on the safety and quality of abortion care in the United States, the National Academies of Sciences, Engineering, and Medicine concluded: "[t]he clinical evidence . . . on the provision of safe and high-quality abortion care *stands in contrast to* the extensive regulatory requirements that state laws impose on the provision of abortion services," including laws that "misinform women of the risks of the procedures they are considering, overrule women's and

clinician's medical decision making, or require medically unnecessary services and delays in care" and those that restrict "provider type" and "provider training."[1]

9. Because the Challenged Laws are inconsistent with the standard of care, they also interfere with the best abortion training, requiring medical students and residents in Michigan to learn to provide abortion care in a legal context that does not best support their practice or patient wellbeing.

10. Only people who seek abortion are subject to the Challenged Laws; not patients seeking any other form of reproductive healthcare or any other form of healthcare, period. Thus, the Challenged Laws also violate the RFFA's nondiscrimination provision by singling out abortion care and abortion patients for unnecessary and harmful regulation.

11. The Challenged Laws are also discriminatory because particular groups of Michiganders bear the brunt of these restrictions, including Black people, indigenous people, low-income people, and rural people.

12. Prior to Michigan voters making their voices heard through the RFFA, the Michigan Legislature piled on restriction after restriction on abortion over the decades following *Roe v Wade*, including medically unjustified facility regulations and the Challenged Laws. The RFFA has rendered these laws plainly unconstitutional. In light of this, the Michigan Legislature enacted a series of bills known as the Reproductive Health Act to repeal many of those restrictions that the Legislature recognized were no longer consistent with the Michigan Constitution. That bill package included the Challenged Laws, until they were omitted at the eleventh hour, despite the fact that they are among the most baseless and harmful restrictions. Once it became clear that the

[1] Nat'l Acads. of Sci., Eng'g, & Med., *The Safety and Quality of Abortion Care in the United States* 11, 77, 163 (Mar. 16, 2018), <https://nap.nationalacademies.org/cart/download.cgi?record_id=24950> (accessed Feb. 4, 2024) (emphasis added).

Legislature was not repealing the Challenged Laws, despite the RFFA, Plaintiffs prepared this lawsuit expeditiously to vindicate the full scope of Michiganders' constitutional rights.

II. JURISDICTION

13. This Court has jurisdiction over this action pursuant to MCL 600.6419(1)(a), which gives the Court of Claims jurisdiction "[t]o hear and determine any claim or demand, statutory or constitutional . . . or any demand for monetary, equitable, or declaratory relief or any demand for an extraordinary writ against the state or any of its departments or officers notwithstanding another law that confers jurisdiction of the case in the circuit court."

14. Plaintiffs' action for declaratory and injunctive relief is authorized by MCR 2.605 and 3.310, and by the general legal and equitable powers of this Court.

III. PARTIES

A. Plaintiffs

a. Northland

15. Northland operates some of the finest outpatient healthcare facilities in the nation. Northland has provided high quality abortion care since 1976.

16. Northland has three reproductive healthcare clinics located in Southfield, Oakland County; Sterling Heights, Macomb County; and Westland, Wayne County. Each location provides medication abortion up to 11 weeks (dated from the pregnant individual's last menstrual period, or "LMP"), and procedural abortion up to 24 weeks LMP.[2]

[2] To preserve accuracy, this complaint uses the terms "woman," "women," "she," or "her" whenever sources categorize people that way. However, Plaintiffs note that people with other gender identities, including transgender men and gender-diverse individuals, may also become pregnant and seek abortion services.

17. Northland regularly trains Obstetrics and Gynecology ("OB/GYN") and Family Medicine residents, OB/GYN fellows, and medical students to provide abortion care. At present, Northland has fellows in rotation.

18. Northland is required to abide by the Challenged Laws, and its clinicians, staff, and patients are harmed by their impact. This is particularly true for the majority of their patients who are people of color and the vast majority who are low income.

b. MSFC

19. MSFC is a 501(c)(3) non-profit organization whose mission is to train tomorrow's abortion providers and pro-choice physicians. MSFC assists medical students and residents to maintain patient access to abortion and family planning education and training, including through curriculum reform, training in a clinic setting, abortion training institutes, and MSFC's two-day annual conference for family planning. MSFC is devoted to expanding access to health services that allow patients to lead safe, healthy lives consistent with their own personal and cultural values, with respect to all aspects of sexual and reproductive health.

20. MSFC has had chapters in Michigan for 25 years. It currently has active chapters at: Central Michigan University College of Medicine, Michigan State University College of Human Medicine East Lansing, Michigan State University College of Human Medicine Grand Rapids, Oakland University William Beaumont School of Medicine, University of Michigan Medical School, Wayne State University School of Medicine, and Western Michigan University Homer Stryker M.D. School of Medicine. Currently, there are approximately 361 MSFC members enrolled in Michigan's medical schools.

21. In the United States, MSFC offers multiple abortion training programs that provide its members with financial and logistical support to receive abortion and family planning training.

First, the Reproductive Health Externship Funding Program provides members with financial support to receive clinical training in abortion care outside of their institution's standard curriculum by spending two to four weeks in a clinic of their choice. Second, the Clinical Abortion Observation program offers members the opportunity to spend anywhere from three to nine days in a clinical setting receiving training in abortion care. Third, MSFC's Abortion Training Institute is an intensive two-day educational opportunity for members to learn about abortion and family planning in a small-group conference setting. In the last decade, 2,350 students have been trained through these programs, around 37 of them from Michigan schools, and 5 of the trainings occurred in Michigan. MSFC members in Michigan coordinate with local organizations on the ground that offer logistical and financial support to pregnant people seeking abortion, and with organizations that advocate for policy changes to improve the reproductive health of Michiganders. MSFC also supports residents through the Training to Competence Externship funding program, which provides medical residents with financial and logistical support for receiving clinical abortion training outside of their program's standard curriculum.

22. MSFC members learn how to provide abortion care and counsel patients in a holistic fashion, including how to obtain individualized informed consent. In addition, MSFC members in Michigan are trained to treat patients, especially those from underserved communities, with compassion, care, and cultural literacy.

23. MSFC's members training in Michigan are harmed by restrictions on abortion care that undermine the standard of care and create health inequities in reproductive health as are their patients. MSFC must make up the difference in training when their members are exposed to training environments that are inconsistent with the best evidence-based medicine.

B. Defendants

24. Defendant Dana Nessel is the Attorney General of Michigan. She is responsible for defending Michigan laws against constitutional challenges. MCL 14.28-14.30; Const 1963, art 5, §§ 1, 3. The Attorney General also acts in a representative and advisory capacity with respect to Michigan administrative agencies, including the Michigan Department of Licensing and Regulatory Affairs ("LARA"). The Michigan Attorney General is sued in her official capacity, as are her agents and successors.

25. Defendant Marlon I. Brown is the Acting Director of LARA. Defendant Brown is sued in his official capacity, as are his agents and successors.

26. Elizabeth Hertel is the Director of the Michigan Department of Health and Human Services. Defendant Hertel is sued in her official capacity, as are her agents and successors.

IV. THE RFFA

27. The constitutional protections afforded by the RFFA form a powerful bulwark against medically unjustified government intrusion and discrimination that confers broad protections for individual reproductive freedom and equality.

28. The RFFA passed with overwhelming support from the people of Michigan. It is among the most robust protections for reproductive freedom in the nation.

29. Under the RFFA, "[e]very individual has a fundamental right to reproductive freedom, which entails the right to make and effectuate decisions about all matters relating to pregnancy, including but not limited to prenatal care, childbirth, postpartum care, contraception, sterilization, abortion care, miscarriage management, and infertility care," and "[t]he state shall not discriminate in the protection or enforcement of this fundamental right." Const 1963, art I, § 28 (1), (2).

30. The RFFA demands that "[a]n individual's right to reproductive freedom shall not be denied, burdened, nor infringed upon unless justified by a compelling state interest achieved by the least restrictive means." Const 1963, art I, § 28 (1). The RFFA specifically defines a state interest as compelling "only if it is for the limited purpose of protecting the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine, and does not infringe on that individual's autonomous decision-making." *Id.* § 28 (4).

31. Further, because the RFFA also prohibits "discriminat[ion] in the protection or enforcement" of the fundamental right to reproductive freedom, abortion restrictions cannot single out abortion for discriminatory treatment or disproportionately harm certain groups, such as protected classes.

V. FACTUAL BACKGROUND

A. Abortion is extraordinarily safe, common, and an essential component of pregnancy care.

32. Abortion is one of the safest medical procedures performed in the United States.[3] Leading medical authorities, including the American College of Obstetricians and Gynecologists ("ACOG"), the American Medical Association ("AMA"), the National Academies, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association, have all concluded that abortion is one of the safest procedures in contemporary medical practice. In its comprehensive report, the National Academies concluded

[3] Nat'l Acads of Sci., Eng'g, & Med., *supra* note 1, at 163–65; *Whole Woman's Health v. Hellerstedt*, 579 U.S. 582, 617–19; 136 S.Ct. 2292, 2315-2316 (2016) (recognizing abortion as a safe procedure with low risk of complications), *abrogated on other grounds by Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 142 S. Ct. 2228 (2022).

that aspiration and medication abortions "rarely result in complications" and do so at rates of "no more than a fraction of a percent."[4]

33. By comparison, vasectomy, a procedure that, like abortion, is frequently performed in a physician's office as a part of reproductive healthcare, has a two percent complication rate, more than double that of abortion.

34. In the first trimester of pregnancy, abortions are performed via medication or procedure. Medication abortion is generally available through 11 weeks LMP. Medication abortion is administered orally, typically with two medications. Patients take the first medication, mifepristone, which stops the pregnancy from growing, and then a second medication, misoprostol, up to 48 hours later, which allows patients to pass the contents of the uterus in a process similar to a miscarriage. Medication abortion is comparable in safety to ibuprofen and acetaminophen.[5]

35. Abortion by procedure in early pregnancy is performed by aspiration, also referred to as "suction curettage." This is a straightforward outpatient procedure through which a clinician removes the contents of the uterus with gentle suction. Procedural abortion is sometimes referred to as "surgical" abortion, although no incision is made. Because there is no incision and instruments are introduced through a body cavity, aspiration abortion does not need to be performed in a sterile operating room. Nor does an aspiration procedure require general anesthesia. The procedure typically takes about five to ten minutes.

36. Starting around 14 weeks LMP, clinicians use forceps or other instruments in addition to gentle suction to remove the contents of the uterus, a procedure known as dilation and

[4] Nat'l Acads of Sci., Eng'g, & Med., *supra* note 1, at 55, 60.

[5] *Id.* at 79.

evacuation or "D&E." Because of its impressive safety record and simplicity, D&E procedures are the most commonly used method of abortion after 14 weeks LMP. D&E is a quick procedure, typically lasting under 10 minutes. Depending on the patient and the method of cervical preparation, abortion providers can perform D&E as a one or two-day procedure. D&E is routinely and safely provided in outpatient, office-based settings nationwide, and generally involves no more than moderate sedation. D&E also requires no incision.

37. The very same medications and procedures used in the context of abortion are used to treat patients experiencing a miscarriage.

38. Induction abortion is the only medically proven alternative to aspiration abortion and D&E available throughout the second trimester. As the name implies, induction abortion involves medications that cause the uterus to contract and the patient to undergo labor. Second trimester induction abortions are very uncommon in the United States because they usually take place in hospitals or similar facilities, last between 8 and 36 hours, and entail contractions and the process of labor, which can be painful and require strong medications, sedatives, or anesthesia. There is also a significant cost difference between an inpatient procedure requiring multiple days of hospitalization and an outpatient procedure such as a D&E.

39. Abortion is far safer than carrying a pregnancy to term, and it has an exceptionally low rate of complication. The risk of mortality of childbirth is 14 times higher than that associated with abortion.[6] Pregnancy complications are also extremely common. They include preeclampsia, a condition that impacts the brain, kidneys, heart, and lungs, and can lead to stroke, seizure, kidney

[6] Raymond et al., *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetric Gynecology 215, 215–19 (Feb. 2012), <http://unmfamilyplanning.pbworks.com/w/file/fetch/119312553/Raymond%20et%20al-Comparative%20Safety.pdf> (accessed Feb. 4, 2024).

failure, liver failure, and hemorrhage. There are numerous maternal conditions that pose a substantial mortality risk in pregnancy, including pulmonary hypertension and maternal cardiac disease, some with mortality risks as high as 50 percent.[7] Many pregnant individuals suffer from gestational diabetes, cardiovascular risk factors, or hypertension and preeclampsia, and these conditions disproportionately impact Black women and other people of color.[8] Pregnancy can also exacerbate mental health conditions, including during the post-partum period.

40. Most people who access abortion care are living in poverty, making up around 75% of people who have abortions due to systemic inequities in health and healthcare access.[9] A large majority of Northland's patients qualify for some kind of financial assistance.

41. People seeking an abortion do so for a wide variety of personal reasons, including familial, medical, and financial reasons. Nearly one in four women in the United States will have had an abortion by the time they are 45 years old.[10]

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[7] Minhas et al., *Racial Disparities in Cardiovascular Complications with Pregnancy-Induced Hypertension in the United States*, 78 Hypertension 480–88 (Aug. 2021), <https://www.ahajournals.org/doi/epub/10.1161/HYPERTENSIONAHA.121.17104> (accessed Feb. 4, 2024).

[8] *Id.*; Bornstein et al., *Racial Disparity in Pregnancy Risks and Complications in the US: Temporal Changes during 2007–2018*, J. Clinical Med., vol. 9, art. No. 1414, at 3–9 (May 2020), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7290488/pdf/jcm-09-01414.pdf> (accessed Feb. 4, 2024).

[9] Jerman et al., *Barriers to Abortion Care and Their Consequences for Patients Traveling for Services: Qualitative Findings from Two States*, 49 Perspectives on Sexual & Reprod. Health (2017), 95–102, <https://www.guttmacher.org/sites/default/files/research_article/file_attachments/4909517.pdf> (accessed Feb. 4, 2024).

[10] Guttmacher Inst, *Induced Abortion in the United States*, <https://www.guttmacher.org/sites/default/files/factsheet/fb_induced_abortion.pdf> (accessed Feb. 4, 2024).

42. People of all religious faiths have abortions: 24% are Roman Catholics; 17% are mainline Protestants; 13% are evangelical Protestants; and 8% belong to other faith traditions.[11]

43. Most abortion patients already have children. Nationally, three-fourths of abortion patients cite responsibility to other individuals (such as children or elderly parents) as a reason for terminating their pregnancy. Many also say they cannot afford to become a parent or to add to their families, and that having a child would interfere with work, school, or the ability to care for dependents.

44. Other abortion patients are experiencing intimate partner violence and may face additional threats to their safety and wellbeing if their partner becomes aware of their pregnancy or desire to obtain an abortion; many such patients fear that being forced to carry a pregnancy to term would further tether them to their abusers. Studies show that women who carry an unwanted pregnancy to term are less likely to leave an abusive relationship because of that connection to their abuser.[12]

45. Some patients seek abortions because they have become pregnant as a result of rape or incest.

46. Some patients decide to have an abortion because their pregnancy has been diagnosed with a condition that means even if a baby is delivered, it would never be healthy enough

[11] *Id.*

[12] Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, BMC Med., 12(144), 5–6 (2014), < https://bmcmedicine.biomedcentral.com/counter/pdf/10.1186/s12916-014-0144-z.pdf > (accessed Feb. 4, 2024); Advancing New Standards in Reprod. Health, *Fact Sheet: The Harms of Denying a Woman a Wanted Abortion* (Apr. 2020) (hereinafter "*Harms of Denying Abortion*"), <https://www.ansirh.org/sites/default/files/publications/files/the_harms_of_denying_a_woman_a_wanted_abortion_4-16-2020.pdf> (accessed Feb. 4, 2024).

to go home. Some abortion patients with high-risk pregnancies have complications that lead them to end their pregnancies to preserve their own life or health.[13]

47. Whatever a patient's reason, accessing abortion is essential to their autonomy, dignity, and ability to care for themselves and their families. Becoming a parent against one's will leads to worse psychological, physical, and economic outcomes than those of pregnant people who are able to access wanted abortion care. A person forced into parenthood is more likely to experience poverty, health difficulties, and physical violence, as are their families.[14] Studies show worse child development outcomes for children of women who have been denied an abortion, and children born out of abortion denial are more likely to live below the federal poverty guidelines compared to children born from a subsequent pregnancy to women who received a wanted abortion.[15]

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[13] Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, Perspectives on Sexual and Reproductive Health 110, 114–16 (2005), <https://www.guttmacher.org/sites/default/files/article_files/3711005.pdf> (accessed Feb. 4, 2024).

[14] Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 Am. J. Pub. Health 407 (2018), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5803812/pdf/AJPH.2017.304247.pdf> (accessed Feb. 4, 2024) (finding "women denied an abortion were more likely than were women who received an abortion to experience economic hardship and insecurity lasting years"); Ralph et al., *Self-Reported Physical Health of Women Who Did and Did Not Terminate Pregnancy After Seeking Abortion Services: A Cohort Study*, 171 Annals Internal Med. 238, 243-45 (2019) (concluding "differences emerged suggesting worse health among those who gave birth" after being denied an abortion than those who underwent abortion) <https://pubmed.ncbi.nlm.nih.gov/31181576/> (accessed Feb. 5, 2024).

[15] Foster et al., *Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children*, 205 J. Ped. 183–89 (2019), <https://www.jpeds.com/action/showPdf?pii=S0022-3476%2818%2931297-6> (accessed Feb. 4, 2024); 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 JAMA Ped. 1053–1060 (2018), <https://jamanetwork.com/journals/jamapediatrics/fullarticle/2698454> (accessed Feb. 4, 2024).

48. In sum, access to abortion is an essential component of comprehensive healthcare, and it is key to facilitating equal participation in society of pregnant Michiganders, including in the economic and social fabric of Michigan. Michiganders must be able to make autonomous personal decisions about whether and when to have children, and they have now enshrined that right in the broadest terms in their state constitution.

B. Michigan law singles out abortion from other reproductive healthcare for uniquely discriminatory treatment.

49. Abortion is subject to restrictions inapplicable to any other form of healthcare provided in Michigan.

50. Decades of legislation siloed abortion from all other areas of medicine in the state. In 1988, the anti-abortion organization Right to Life of Michigan led citizen petition drives that prohibited Medicaid funding for abortion, MCL 400.109a.

51. In 1993, the Legislature enacted the Challenged Laws.[16] Those requirements were modified repeatedly over time through litigation, settlement, and further legislation.[17]

52. In 2012, the legislature passed H.B. 5711, known as the Abortion Omnibus Bill, which consolidated 7 previously introduced bills and created onerous and unnecessary facilities requirements, among other harms.[18]

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[16] *Clarify Abortion Informed Consent: Third Analysis,* Michigan House Fiscal Agency, Dec 22, 2000, <https://www.legislature.mi.gov/documents/1999-2000/billanalysis/House/htm/1999-HLA-5548-C.htm> (accessed Feb. 4, 2024).

[17] *Id.*; *Restrict Requirement of Prepayment for Abortion: First Analysis,* House Legislative Analysis Section, May 15, 2002, <http://www.legislature.mi.gov/documents/2001-2002/billanalysis/House/pdf/2001-HLA-5971-a.pdf> (accessed Feb. 4, 2024); *Michigan's Informed Consent for Abortion Law,* MDHHS, <https://www.michigan.gov/mdhhs/adult-child-serv/informedconsent> (accessed Feb. 4, 2024).

[18] *Legislative Analysis: Abortion-Related Amendments*, House Fiscal Agency, Sept. 11, 2012, at 9, http://www.legislature.mi.gov/documents/2011-2012/billanalysis/House/pdf/2011-HLA-5711-3.pdf (accessed Feb. 4, 2024); Abortion Related Amendments Second Legislative Analysis, House

53. Piling on, in 2013, the State mandated that all abortions other than to avert a patient's death could be covered in healthcare plans only by optional riders, even in cases of rape and incest. Act 182 of 2013, codified as MCL 550.541-550.551.

54. Today, while some of the harmful laws mentioned above have been repealed, the 24-Hour Delay, Mandatory Biased Counseling, and Provider Ban have not, despite the fact that they are among the most burdensome restrictions for patients and directly interfere with their access to abortion and decision-making.

55. The legislative overlay created by the Challenged Laws, applicable solely to abortion services, is unique among all other medical care in Michigan. Pregnant patients who are not seeking abortions are not similarly restrained from obtaining the pregnancy care they require. So too, no other Michiganders experience equivalent barriers when seeking any other comprehensive reproductive or other health care—even services that are not constitutionally protected. Only pregnant individuals, and specifically those seeking abortions, are singled out in this way.

56. No other patients are forced to delay essential and time-sensitive healthcare or forced to consume non-individualized, irrelevant, and stigmatizing information. The State does not attempt to dissuade other people seeking healthcare from choosing care that is best for them. In no other area of healthcare are qualified trained clinicians specifically barred from providing services consistent with their training and experience. There is nothing like the Challenged Laws anywhere else in Michigan's regulation of healthcare and for obvious reason. Abortion was singled out because of opposition to it and for no health-related reason at all.

Fiscal Agency, Feb 14, 2013, at 14-25, <https://www.legislature.mi.gov/documents/2011-2012/billanalysis/House/pdf/2011-HLA-5711-28C443C7.pdf> (accessed Feb. 4, 2024).

57. These restrictions also promote stereotyped notions that motherhood is the preferred, natural, and proper state for Michiganders who become pregnant, and that they are not capable of making decisions about the timing, number, and spacing of children, but rather must be protected from the consequences of making decisions others see as wrong. They also reflect the blatant falsehood that abortion is unsafe when it is among the safest healthcare available in the U.S.

C. Restricting access to abortion disproportionately harms communities of color and other people facing systemic barriers to healthcare access.

58. There are significant disparities in access to abortion nationally and in Michigan, specifically. People who already face significant barriers to healthcare access, including Black women and other people of color, indigenous people, people living on low incomes, and rural people, face disproportionate barriers in accessing abortion. These disparities are particularly significant in Michigan because of the challenges these communities have historically faced in the state.

59. About 87% of Michigan counties have no abortion clinics, but over one-third of Michiganders of reproductive capacity live in these counties.[19]

60. Michigan has large rural areas that make transportation difficult. The Upper Peninsula and northeastern Lower Peninsula do not contain a single urban county.[20]

61. Traveling to an abortion clinic may pose extreme difficulties for people of color, indigenous people, low-income people, and rural people who lack access to public transportation or their own household vehicle. Around 18% of Black households in Michigan do not have access

[19] *State Facts About Abortion: Michigan*, Guttmacher Inst (2022), <https://www.guttmacher.org/sites/default/files/factsheet/sfaa-mi.pdf> (accessed Feb. 4, 2024).

[20] Wendling et al., *Access to Maternity and Prenatal Care Services in Rural Michigan*, 48 Birth 566, 567 (Dec. 2021), <https://onlinelibrary.wiley.com/doi/epdf/10.1111/birt.12563> (accessed Feb. 4, 2024).

to a car.[21] In addition, low-income people and people of color already live in public transit deserts. "Michiganders who take public transportation spend an extra 67.7% of their time commuting and non-White households are 5.6 times more likely to commute via public transportation. 17% of trains and other transit vehicles in the state are past useful life."[22] Research consistently shows that access to abortion care is sensitive to increases in logistical burdens—even small increases in travel distance or congestion at abortion facilities due to reduced access can stop people from getting care and force them to carry an unwanted pregnancy to term.[23]

62. Struggling families in Michigan also do not have adequate access to general healthcare, prenatal and post-natal care, parental leave, childcare, lactation support, and

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[21] *Summary Data Brief of the Changes in Health Disparities Between 2018-2020* (hereinafter "*Health Disparities*"), at 2, Michigan Dep't Health & Human Servs., <https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Keeping-Michigan-Healthy/Chronic-Disease/OEMH/Summary_Data_Brief_of_the_Changes_in_Health_Disparities_Between_2018-2020.pdf?rev=0dced0bfcf0a42d3818b8ab50be82965&hash=39117B5A95BA0A20AD37D082A8550332> (accessed Feb. 4, 2024).

[22] *American Jobs Plan: The Need for Action in Michigan*, White House (2021), <https://www.whitehouse.gov/wp-content/uploads/2021/04/AJP-State-Fact-Sheet-MI.pdf> (accessed Feb 4, 2024).

[23] Grossman, *The Use of Public Health Evidence in Whole Woman's Health v Hellerstedt*, 177 JAMA Internal Med. 155-56 (2017) <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2580725> (accessed February 5, 2024); Lindo et al., *How Far Is Too Far? New Evidence on Abortion Clinic Closures, Access, and Abortions*, 55 J. Hum. Res. 1137 (2020) <https://jhr.uwpress.org/content/55/4/1137> (accessed Feb. 5, 2024); Quast et al., *Abortion Facility Closings and Abortion Rates in Texas*, 54 Inquiry 1 (2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5798726/pdf/10.1177_0046958017700944.pdf> (accessed Feb. 4, 2024); 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 (2018) <https://www.nber.org/papers/w23634> (accessed Feb. 5, 2024); Venator et al., *Undue Burden Beyond Texas: An Analysis of Abortion Clinic Closures, Births, and Abortions in Wisconsin*, 40 J. Pol'y Analysis & Mgmt. 774 (2020), <https://onlinelibrary.wiley.com/doi/epdf/10.1002/pam.22263> (accessed Feb. 4, 2024).

accommodations for disabilities. In Michigan, more women than men are impoverished.[24] Moreover, a large proportion of these struggling families are Black. Between 2018 and 2020, 35% of Black Michiganders lived in poverty, more than twice the overall Michigan poverty rate and far higher than the national Black poverty rate (20.8%).[25]

63. In Michigan, more than half of abortion patients are Black.[26] The majority of Northland's patients are Black women or other people of color. That abortion restrictions fall hardest on communities of color is no accident. Abortion restrictions are part and parcel of America's history of reproductive and sexual control policies targeting pregnant individuals, especially Black and indigenous women. Reproductive control policies have been used to systematically deprive pregnant individuals of the liberty to make decisions about when, whether, and under what conditions to birth and raise children. These state-sanctioned policies have included enslavement and forced birth, the removal of children from their families and cultures, sterilization, and contraception and abortion restrictions.[27] The impact of these harms over time

[24] *Status of Women in the States*, Institute for Women's Policy Research (2018), <https://statusofwomendata.org/wp-content/themes/witsfull/factsheets/economics/factsheet-michigan.pdf> (accessed Feb. 4, 2024).

[25] *Health Disparities*, *supra* 21note 21, at 2; *Historical Poverty Table 2: Poverty Status of People by Family Relationship, Race, and Hispanic Origin* – 1959 to 2022, U.S. Census Bur. (Sep. 12, 2023), <https://www2.census.gov/programs-surveys/cps/tables/time-series/historical-poverty-people/hstpov2.xlsx> (accessed Feb. 4, 2024).

[26] *Table 11: Number and Percent of Reported Induced Abortions by Race or Hispanic Ancestry of Woman, Michigan Residents, 2022*, Mich. Dep't Comm'y Health (2022), <https://www.mdch.state.mi.us/osr/abortion/Abortrace.asp#> (accessed Feb. 4, 2024).

[27] *See, e.g.*, Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (1997); Stern, *Forced Sterilization Policies in the US Targeted Minorities and Those with Disabilities – and Lasted Into the 21st Century*, U. Mich. Inst. For Healthcare Policy & Innovation (Sept. 23, 2020), <https://web.archive.org/web/20201201185614/https://ihpi.umich.edu/news/forced-sterilization-policies-us-targeted-minorities-and-those-disabilities-and-lasted-21st> (accessed Feb. 4, 2024).

can be felt in today's entrenched inequities in health and access to healthcare. As a result, today's abortion restrictions cut deepest into communities that have suffered generations of reproductive coercion and discrimination.

64. One of the most devastating manifestations of these inequities is the maternal health crisis affecting Black women and other people of color. Forcing these communities to experience unnecessary burdens and delays in accessing reproductive healthcare or to carry unwanted pregnancies perpetuates systemic discrimination by worsening the maternal mortality crisis and exacerbating racial health disparities. According to a recent report by the World Health Organization, our country is one of only 13 countries worldwide with a rising maternal mortality rate and is the only country with an advanced economy where the rate is worsening.[28] In Michigan, maternal mortality is dramatically worse for Black women than white women. Between 2014 and 2018, Black women were approximately 2.8 times more likely to die from pregnancy-related causes.[29] This racial disparity is even higher in Detroit. In general, the maternal death rate in Detroit is three times the national average. But pregnant Black women in Detroit are at even greater risk; they are 4.5 times more likely to die than white women.[30]

65. Pregnancy carries numerous risks of complications and conditions that pose a

[28] World Health Organization et al., *Trends in Maternal Mortality: 1990 to 2015: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division* (2015), at 70-77, <http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf> (accessed Feb. 3, 2024).

[29] Mich Dep't of Health & Hum Servs., *Maternal Deaths in Michigan, 2014-2018 Data Update,* at 6, <https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/MCH-Epidemiology/MMMS_2014-2018_Pub_Approved.pdf> (accessed Feb. 4, 2024).

[30] Whitaker, *Black Maternal Mortality Rate* (City of Detroit City Council Legislative Policy Division 2022), at 5, <https://detroitmi.gov/sites/detroitmi.localhost/files/2022-05/Black%20Maternal%20Mortality%20Rate%205-5-2022%20final%20-%20ST.pdf> (accessed Feb. 4, 2024).

substantial mortality risk, such as preeclampsia, pulmonary hypertension and maternal cardiac disease, some with mortality risks as high as 50 percent. These conditions affect Black women at higher rates than white women.[31]

66. Nationwide, maternal morbidity also reflects racial inequality.[32] Maternal morbidity refers to cases in which a pregnant person faces a life-threatening diagnosis or must undergo a life-saving medical procedure—like a hysterectomy, blood transfusion, or mechanical ventilation—to avoid death.[33] For every maternal death in the country, there are close to 100 cases of severe maternal morbidity.[34] Black women are twice as likely as their white counterparts to suffer severe maternal morbidity.[35] Indeed, Black women have the highest rates for 22 of 25 severe morbidity indicators used by the Center for Disease Control ("CDC").[36] Delivery through cesarean section, which carries risks of hemorrhage, infection, and injury to internal organs, is also more

[31] Minhas et al, *supra* note 7.

[32] *See* Creanga et al, *Racial and Ethnic Disparities in Severe Maternal Morbidity: A Multistate Analysis, 2008-2010,* 210 Am J Obstetrics & Gynecology 435 (2014), <https://www.ajog.org/action/showPdf?pii=S0002-9378%2813%2902153-4> (accessed Feb. 4, 2024); Admon et al., *Racial and Ethnic Disparities in the Incidence of Severe Maternal Morbidity in the United States, 2012-2015*, 132 Obstetrics & Gynecology 1158 (2018), <https://journals.lww.com/greenjournal/fulltext/2018/11000/racial_and_ethnic_disparities_in_the_incidence_of.11.aspx>.(accessed Feb. 4, 2024).

[33] Howell, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61 Clinical Obstetrics & Gynecology 387 (2018), <https://journals.lww.com/clinicalobgyn/fulltext/2018/06000/reducing_disparities_in_severe_maternal_morbidity.22.aspx> (accessed Feb. 4, 2024).

[34] *Id.*

[35] Creanga et al., *supra* note 32.

[36] Howell, *supra* note 33, at 388.

common among Black than white women.[37]

67. For people with existing medical co-morbidities, forced pregnancy results in more high-risk pregnancies and increased risk for severe maternal morbidity and mortality. Such severe maternal morbidity and mortality disproportionately affects Black women. [38]

68. Research shows that the stress of racism itself creates a "weathering" effect that may lead to poor health outcomes, including the development of chronic conditions.[39] During pregnancy, these health risks increase for Black individuals because they disproportionately face systemic racism, poverty, provider bias, and lack of access to prenatal and post-natal care.[40]

69. In addition, a person's ability to access abortion has consequences not only for that person, but also for a whole network of other people who rely on those individuals. In Michigan, two-thirds of abortion patients have already given birth, and over 40% have given birth at least

[37] Martin et al., *Birth: Final Data for 2019*, 70 Nat'l Vital Stats Report 8 (2021), <https://stacks.cdc.gov/view/cdc/100472> (accessed Feb. 4, 2024).

[38] Aziz et al*., Termination of Pregnancy as a Means to Reduce Maternal Mortality in Pregnant Women With Medical Comorbidities*, 134 Obstetrics and Gynecology 1105 (2019), <https://journals.lww.com/greenjournal/fulltext/2019/11000/termination_of_pregnancy_as_a_means_to_reduce.25.aspx> (accessed Feb. 4, 2024).

[39] Roeder, *America is Failing Its Black Mothers*, Harvard Pub. Health (2019), <https://www.hsph.harvard.edu/magazine/magazine_article/america-is-failing-its-black-mothers/> (accessed Feb. 4, 2024).

[40] *Id*.

twice. A vast number of Michigan families with children live in a single parent household—33.5%.[41] In addition, in the U.S., 16.9% of Black women provide unpaid eldercare.[42]

70. Being able to choose when and whether to be pregnant and parent a child is tied to the overall economic and social health of communities, and this is particularly so for Black communities given the structural barriers to equality they face. Restricting abortion thus impacts the ability of communities of color to advance in Michigan by inhibiting access to education and higher income employments.

VI. THE CHALLENGED LAWS VIOLATE THE RFFA

96. The Challenged Laws are comprised of two statutes that violate the RFFA by intruding on an individual's constitutional right to abortion without any justification, much less a compelling one, and doing so in discriminatory ways. MCL 333.17015, 333.17015a. The Challenged laws "den[y], burde[n]," and "infringe[]" the right to abortion without serving—*in any way*—the "limited purpose of protecting the health of an individual seeking care." Const 1963, art I, § 28. Each is "[in]consistent with accepted clinical standards of practice and evidence-based medicine." *Id.* § 28(4). And each law intrudes "on [an] individual's autonomous decision-making." *Id.* Further, they all cause significant harm to pregnant Michiganders.

97. The RFFA also prohibits "discriminat[ion] in the protection or enforcement of this fundamental right," *id.*, such that restrictions on reproductive freedom cannot stand if they privilege some reproductive choices over others, including by subjecting abortion to unique

[41] Mich. League for Pub Pol'y, *2021 Kids Count in Michigan Data Book*, at 35, <https://mlpp.org/wp-content/uploads/2021/06/2021-kids-count-in-michigan-data-book.pdf> (accessed Feb. 4, 2024).

[42] US Bureau of Lab Stats, *Unpaid Eldercare in the United States News Release*, <https://www.bls.gov/news.release/elcare.htm> (accessed Feb. 4, 2024).

restrictions not applicable to other pregnancy care. Restrictions on abortion also cannot disproportionately harm certain groups, such as Black women and other people of color.

A. The 24-Hour Delay

65. The 24-Hour Delay forces patients to wait a minimum of 24 hours after receiving the Mandatory Biased Counseling before they can obtain an abortion. Far from benefiting patients, delay pushes patients seeking abortion care to obtain that care later in pregnancy or, in some cases, not at all. Moreover, because the 24-Hour Delay causes patients to delay care, providers in Michigan are prevented from encountering patients in the best position for care and from providing abortion care that is timely and medically and scientifically indicated.

66. The majority of patients meet the requirements to trigger the 24-hour delay period by accessing a website maintained and operated by the Michigan Department of Health and Human Services. The website requires that a patient read and click through several pages of information—on the procedure, on gestational age and fetal development, and on prenatal care and parenting—which then prompts the patient to sign an acknowledgement and consent form. MCL 333.17015(5).

67. Patients who access the website are required to print a "confirmation form from the website that the patient has reviewed" this information "at least 24 hours before an abortion being performed on the patient" and "supply the valid confirmation" to the provider. MCL 333.17015(5). This printing requirement, itself, imposes extra burdens on abortion patients.

68. Mandatory delay periods like Michigan's are purportedly justified on the basis that they help patients be more certain about their decision to have an abortion and prevent regret and

mental health harms.[43] Indeed, § 333.7015 requires the Michigan Department of Health and Human Services to create materials that inform patients of risks of "depression" and "feelings of guilt." MCL 333.17015(11)(b)(iii). But a robust body of research demonstrates that most women seeking an abortion in the United States are already certain of their decision by the time they present for care and that mandatory delays do not improve certainty.[44] Further, decades of empirical research looking at the effects of abortion on women's mental health have found that there is no evidence that safe, legal abortion care harms a woman's mental health, whether due to regret or anything else.[45]

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[43] Jovel et al., *Abortion Waiting Periods and Decision Certainty Among People Searching Online for Abortion Care*, Obstetrics and Gynecology, 137(4): 597-605 (2021), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7984762/pdf/ong-137-597.pdf> (accessed Feb. 4, 2024).

[44] Ralph et al., *The Impact of a Parental Notification Requirement on Illinois Minors' Access to and Decision-Making Around Abortion*, Journal of Adolescent Health, 62(3): 281-287 (2018) <https://pubmed.ncbi.nlm.nih.gov/29248391/> (accessed Feb. 5, 2024); Ralph et al., *Measuring Decisional Certainty Among Women Seeking Abortion*, Contraception, 95: 268-278 (2017) <https://pubmed.ncbi.nlm.nih.gov/27745910/> (accessed Feb. 5, 2024); Roberts et al., *Do 72-Hour Waiting Periods and Two-Visit Requirements for Abortion Affect Women's Certainty? A Prospective Cohort Study*, Women's Health Issues, 27(4): 400-406 (2017) <https://pubmed.ncbi.nlm.nih.gov/28391971/> (accessed Feb. 5, 2024); Roberts et al., *Utah's 72-Hour Waiting Period for Abortion: Experiences Among a Clinic-Based Sample of Women*, Perspectives on Sexual and Reproductive Health, 48(4): 179-187 (2016) <https://onlinelibrary.wiley.com/doi/epdf/10.1363/48e8216> (accessed Feb. 4, 2024); Gould et al., *Predictors of Abortion Counseling Receipt and Helpfulness in the United States*, Women's Health Issues, 23(4): 249-255 (2013) <https://www.whijournal.com/article/S1049-3867(13)00039-X/fulltext> (accessed Feb. 5, 2024); Foster et al., *Attitudes and Decision Making Among Women Seeking Abortions at One US Clinic*, Perspectives on Sexual and Reproductive Health, 44(2): 117-124 (2012), <https://www.guttmacher.org/sites/default/files/article_files/4411712.pdf> (accessed Feb. 4, 2024); *see also* Kumar, U., et al., *Decision Making and Referral Prior to Abortion: A Qualitative Study of Women's Experiences*, Journal of Family Planning and Reproductive Health Care, 30(1): 51-54 (2004),<https://srh.bmj.com/content/familyplanning/30/1/51.full.pdf> (accessed Feb. 4, 2024).

[45] Nat'l Acads. of Sci., Eng'g, & Med., *supra* note 1, at 149-152; Academy of Medical Royal Colleges, *Induced Abortion and Mental Health* 1-248 (2011) <https://www.aomrc.org.uk/wp-

69. Abortion providers are trained to provide individualized informed consent counseling. MSFC's programs, for example, provide such training and teach about how to counsel patients holistically, including by assessing their certainty and encouraging them to take as much time as they need.

70. Northland reports that they have never seen the 24-Hour Delay benefit a single patient. The vast majority of Northland's patients are certain of their decision well before they walk through Northland's doors. And Northland's holistic counseling and informed consent process ensures that patients are informed about their care and that Northland addresses their needs in an individualized manner. For patients who are uncertain, they can take all the time they need to come to a decision. Like any quality healthcare provider, Northland does not provide services to people who are undecided about receiving care.

71. While abortion is extremely safe, delay incrementally increases the risks and complexity of abortion. Forcing pregnant people to delay abortion care is thus detrimental to their health and exposes them to greater risks with no medical justification.[46] For this reason, the

content/uploads/2016/05/Induced_Abortion_Mental_Health_1211.pdf> (accessed Feb. 4, 2024); Major et al., *Abortion and mental health: Evaluating the evidence*, American Psychologist, 64(9):863-890 (2008) <https://www.apa.org/pubs/journals/features/amp-64-9-863.pdf> (accessed Feb. 4, 2024); Charles et al., *Abortion and long-term mental health outcomes: a systematic review of the evidence*, Contraception 78(6): 436-50 (2008) <https://pubmed.ncbi.nlm.nih.gov/19014789/> (accessed Feb. 5, 2024); Adler et al., *Psychological factors in abortion: A review*, American Psychologist, 47(10): 1194-1204 (1992) <https://pubmed.ncbi.nlm.nih.gov/1443858/> (accessed Feb. 5, 2024).

[46] Nat'l Acads. of Sci., Eng'g, & Med., *supra* note 1, at 77-78; Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, Obstetrics and Gynecology, 103(4): 729-737 (2004) <https://pubmed.ncbi.nlm.nih.gov/15051566/> (accessed Feb. 5, 2024).

National Academies recommends that abortion be performed "as early in pregnancy as possible," and considers timeliness one of the core dimensions of high quality care.[47]

72. In addition, studies have found that mandatory delay laws exacerbate the burdens that people experience in seeking abortion care, including by increasing costs, prolonging wait times, increasing the risk that a woman will have to reveal her decision to others, and potentially preventing a woman from having the type of abortion that she prefers or any abortion at all.[48] Mandatory waiting periods can place additional emotional burdens on women, causing them increased anxiety and discomfort.[49]

73. For example, a 2009 literature review of studies evaluating the impact of mandatory counseling and waiting period laws concluded that such laws are likely to increase both the personal and financial costs of obtaining an abortion, which may prevent some women from accessing abortion services altogether.[50] The review also found that such laws may delay women who are seeking abortions and result in a higher proportion of second-trimester abortions.[51]

74. Delay can mean that some pregnant people become ineligible for the abortion method most appropriate for them, and instead must undergo a more invasive, more expensive,

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[47] Nat'l Acads. of Sci., Eng'g, & Med., *supra* note 1, at 163.

[48] Roberts et al. (2016), *supra* note 44, at 184-186; White et al., *Experiences Accessing Abortion Care in Alabama Among Women Traveling for Services*, 26 Womens Health Issues 298–304 (2016), <https://pubmed.ncbi.nlm.nih.gov/26897655/>; Joyce et al., *The Impact of State Mandatory Counseling and Waiting Period Laws on Abortion: A Literature Review* 11, 15, Guttmacher Inst. (2009), <https://www.guttmacher.org/sites/default/files/pdfs/pubs/MandatoryCounseling.pdf> (accessed Feb. 4, 2024).

[49] Roberts et al., *supra* note 44, at 184-185.

[50] Joyce et al., *supra* note 48, at 7–10.

[51] *Id.* at 9.

and/or lengthier abortion procedure. Medication abortion, which is preferred by many, and is the most common method of abortion in the United States, is available at Northland only up to 11 weeks, and even a short delay can push patients outside this window. Delay can also mean that people become ineligible for a first trimester abortion (available up to 13 weeks, 6 days LMP), and are forced to incur substantially higher costs to obtain a second trimester abortion. Later in pregnancy, procedural abortion becomes more complex—as pregnancy advances beyond approximately 14 weeks, it can become a two-day procedure to accomplish advanced dilation of the cervix.

75. The 24-Hour Delay's impacts are particularly severe for those who already face systemic barriers to accessing care, including Black women and other people of color, indigenous people, low-income people, and rural people, which makes the impact of the delay on these groups particularly severe. And it can be very difficult for people living on low incomes to take time off work and arrange childcare. People without means already face burdens in saving enough money to afford a first trimester procedure. For patients who struggle to afford a first trimester procedure, a second trimester procedure could be financially out of reach. Most patients who access abortion at Northland require some kind of financial assistance.

76. The printing requirement is particularly burdensome as most of Northland's patients don't have printers or computers at home—most use a smart phone as their sole device. Northland reports that at least 10 patients a month are waylaid by this requirement. They come in for care, but are told that they need to sign a physical copy of the acknowledgement and consent form and then are forced to wait another 24 hours.

77. Delays are all the more problematic in the post-*Roe* world, where people are traveling long distances to seek care in the states where abortion remains legal.

78. Further, the 24-Hour Delay impedes medical training for MSFC's members because the requirement is devoid of a scientific basis and inconsistent with the standard of care. When medical students or residents navigate a restriction to medical care that does not benefit patient outcomes and is not based in science, they are no longer learning medicine in an environment that is consistent with best educational practices.

79. Michigan does not impose any such mandatory delay on any other procedures, including medical procedures that pose far greater risks than abortion.

80. For all of these reasons, the 24-Hour Delay violates the fundamental constitutional right to abortion enshrined in the RFFA. And, because it discriminates against people who seek one form of reproductive healthcare and disproportionately impacts communities of color, low-income people, rural people, and others who face systemic barriers to healthcare access, it also violates RFFA's prohibition on discrimination. Further, the requirement harms Northland and MSFC individually by undermining the provision of evidence-based care and evidence-based medical training.

B. The Mandatory Biased Counseling

81. This one-size-fits-all requirement that providers dispense the State's version of relevant information does not provide any medical benefit and actually thwarts the true goals of informed consent, which is inherently individualized. State-mandated counseling also undermines autonomous decision-making. The Mandatory Biased Counseling forces providers to tell patients information that is unnecessary, irrelevant, inaccurate, and/or stigmatizing—all for the purpose of dissuading people from choosing to have an abortion. The requirement damages patient-provider trust and takes time and attention away from information targeted at the individual patient's needs. The requirement also undermines medical training, as MSFC members are forced to learn how to

counsel patients in a legal context that does not support learning the best evidence-based counseling and informed consent practices.

82. The statute requires that an abortion provider must—not less than 24 hours before performing an abortion—(1) confirm the patient is pregnant and determine the probable gestational age of the fetus; (2) orally describe to the patient the gestational age, information about what to do should any complications arise from the abortion, and information about how to obtain pregnancy prevention resources; and (3) provide the patient with physical copies of the following: a summary of the procedure, a medically accurate depiction of a fetus at the gestational age nearest the probable gestational age of the patient's fetus, a prenatal care and parenting information packet, and a prescreening summary on prevention of coercion to abort. MCL 333.17015(3).

83. In addition, after a patient arrives for their appointment, before obtaining the patient's signature on the acknowledgement and consent form, "a physician personally . . . shall" (1) confirm that the patient has received a screening on coercion to abort; (2) inform the patient of the right to withhold or withdraw consent at any time before performance of the abortion; and (3) orally describe risks of any complications associated with abortion as well as risks of any complications that could arise should the patient choose to continue the pregnancy. *Id.* 333.17015(6).

84. The Mandatory Biased Counseling is at odds with the standard of care, which requires an unbiased, individualized informed consent process. The standard of care before providing any abortion is to provide patients with information that is necessary and relevant to their decision-making, including risks, benefits, and alternatives, afford the opportunity to ask questions, and ensure that the patient is certain of their decision. Abortion providers like Northland

are guided by ethical principles and professional standards in informing their patients with accurate, adequate, and understandable information that is individualized and medically relevant.

85. According to ACOG, "[t]he highest ethical standard for adequacy of clinical information requires that the amount and complexity of information be tailored to the desires of the individual patient and to the patient's ability to understand this information."[52] As a result, ACOG opposes laws that "interfere with the ability of physicians to have open, honest, and confidential communications with their patients."[53] Laws that "interfere with the patient's right to be counseled by a physician according to the best currently available medical evidence and the physician's professional medical judgment" are contrary to informed consent.[54] Indeed, "[e]xamples of legislative interference in the informed consent process include state-mandated consent forms" and "laws that require physicians to give, or withhold, specific information when counseling patients before undergoing an abortion."[55]

86. Informed consent is grounded in respect for patient autonomy—its purpose is to ensure that patients have control over their own bodies and can make their own healthcare decisions. A respectful informed consent process is critical to establishing trust between patients and providers. Non-medical, inaccurate, irrelevant, or biased information undermines these principles. Conveying the state's disapproval of a patient's healthcare choices is the antithesis of

[52] American College of Obstetricians & Gynecologists, ACOG Committee Op. No. 819 (Feb. 2021), <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2021/02/informed-consent-and-shared-decision-making-in-obstetrics-and-gynecology.pdf> (accessed Feb. 4, 2024).

[53] *Id.*

[54] *Id.*

[55] *Id.*

informed consent, as is forcing patients to consume uniform information not tailored to their individual circumstances.

87. Northland reports that they have never seen the Mandatory Biased Counseling benefit a single patient. Rather, the requirement is a needless overlay that takes time away from the actual, holistic counseling Northland does with each patient. When MSFC provides and facilitates training for its members, it needs to ensure that they are learning how to counsel patients via the best evidence-based methods. Forcing providers to dispense and patients to consume unnecessary, misleading, inaccurate, and/or stigmatizing information is not consistent with evidence-based medicine.

88. The Mandatory Biased Counseling contains extensive fetal imagery and is heavily weighted toward encouraging continuing a pregnancy. These materials are designed to induce shame and persuade people to change their mind about having an abortion regardless of their personal circumstances. According to providers, the fetus in the image included in the mandatory materials is often more developed than an actual fetus, making this information inaccurate, misleading, and even disturbing.

89. MCL 333.17015 also requires the Michigan Department of Health and Human Services to create materials that inform patients of risks of "depression" and "feelings of guilt" and "[i]dentify services available through public agencies" should a patient "experience subsequent adverse psychological effects from" an abortion. *Id.* 333.17015(11)(b)(iii), (vii). But people are *not* more likely to experience depression after having an abortion.[56] They are, however,

[56] Nat'l Acads. of Sci., Eng'g, & Med., *supra* note 1, at 151; Academy of Medical Royal Colleges, *supra* note 45, at 98-99, 123-125; Major et al., *supra* note 45; Charles et al., *Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence*, Contraception 78(6):436-50 (2008) <https://pubmed.ncbi.nlm.nih.gov/19014789/> (accessed Feb. 5, 2024); Adler et al.

more likely to experience lower self-esteem, lower life satisfaction, and more anxiety symptoms if they cannot access a wanted abortion.[57]

90. Further, most people who have abortions are already parents. It is particularly inappropriate to inundate these patients with materials on prenatal care and parenting. The information is cruel to those with much wanted pregnancies who choose to have an abortion because of a severe diagnosis.

91. Patients must also be "screened" for coercion via a uniform set of requirements under the challenged statute. MCL 333.17015a. But providers already ensure that patients are not facing coercion. Further, for patients experiencing intimate partner violence who choose abortion to avoid being further tethered to their abuser, this screening can be upsetting and a grave interruption in the trust they have with their provider.

Psychological Factors in Abortion: A Review, American Psychologist, 47(10): 1194-1204 (1992) <https://pubmed.ncbi.nlm.nih.gov/1443858/> (accessed Feb. 5, 2024).

[57] Biggs et al., *Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Study,* JAMA Psychology, 74(2): 169-178 (2017), <https://docs.house.gov/meetings/IF/IF14/20200212/110504/HHRG-116-IF14-20200212-SD046.pdf> (accessed Feb. 4, 2024); *See also* Biggs et al., *Does Abortion Increase Women's Risk for Post-Traumatic Stress?: Findings From a Prospective Longitudinal Cohort Study*, BMJ Open, 6(2): e009698 (2016) <https://bmjopen.bmj.com/content/bmjopen/6/2/e009698.full.pdf> (accessed Feb. 4, 2024); Biggs et al., *Mental Health Diagnoses 3 Years After Receiving or Being Denied an Abortion in the United States*, American Journal of Public Health, 105(12): 2557-2563 (2016) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4638270/pdf/AJPH.2015.302803.pdf> (accessed Feb. 4, 2024); 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*, BMC Women's Health, 14: 76 (2014) <https://bmcwomenshealth.biomedcentral.com/counter/pdf/10.1186/1472-6874-14-76.pdf> (accessed Feb. 4, 2024); Jovel et al., *Abortion Waiting Periods and Decision Certainty Among People Searching Online for Abortion Care*, Obstetrics and Gynecology, 137(4): 597-605 (2021), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7984762/pdf/ong-137-597.pdf> (accessed Feb. 4, 2024).

92. No other form of healthcare in Michigan is subject to an overlay of uniform materials and information, much less information that is biased and designed to discourage people from accessing care. Healthcare providers in every other area of medicine in Michigan obtain informed consent through an individualized process in line with the standard of care for their specialties and their ethical obligations.

93. Further, Black women and other people of color, indigenous people, low-income people, and rural people, among others who face systemic barriers to healthcare access are disproportionately impacted by stigma and coercion based on the history of discrimination they have faced, including within the healthcare system. The Mandatory Biased Counseling undermines the patient-provider relationship, which reinforces the ways these communities have already had their reproductive choices manipulated.

94. For all of these reasons, the Mandatory Biased Counseling violates the fundamental constitutional right to abortion enshrined in the RFFA. And because it discriminates against people who seek one form of reproductive healthcare and disproportionately impacts communities of color, low-income people, rural people, and others who face systemic barriers to healthcare access, it also violates the RFFA's prohibition on discrimination. Further, the requirement harms Northland and MSFC individually by undermining the provision of evidence-based care and evidence-based medical training.

C. The Provider Ban

95. The Challenged Laws also include a "physician only" provision that thereby bans health care providers who are not physicians from providing abortions, *i.e.*, the Provider Ban. MCL 333.17015 (a "*physician* shall not perform an abortion . . . without the patient's informed written consent . . .") (emphasis added).

96. But for the Provider Ban, Northland and other providers in Michigan could hire Advanced Practice Clinicians ("APCs") like Certified Nurse Midwives ("CNMs"), Nurse Practitioners ("NPs"), and Physician Assistants/Associates ("PAs") to provide early abortions and thus greatly expand available services and appointments. Hiring APCs to provide abortions would also free up physician time for more complex care. The increased availability of procedural care is particularly important in the post-*Roe* world because so many patients are traveling long distances.

97. APCs are highly qualified clinicians who, based on advanced education and training, have a broad scope of practice, including extensive prescriptive authority and the ability to perform a range of complex medical procedures. APCs routinely provide abortions in other states, including in California, Colorado, Illinois, Maine, Montana, New Hampshire, New York, Oregon, Vermont, Virginia, Washington, Connecticut, Hawaii, Maryland, New Jersey, Rhode Island, and the District of Columbia.

98. Research shows no difference in outcomes between an early abortion provided by an APC and one provided by a physician.[58] Complication rates and other safety measures are the same.[59]

99. For these reasons, every mainstream professional organization to weigh in on APCs providing abortions has affirmed that these clinicians should not be prohibited from providing

[58] Am. Coll. of Obstetricians & Gynecologists (Dec. 2020), ACOG Committee Op. No. 815 (replacing Committee Opinion No. 613) (Nov. 2014), <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2020/12/increasing-access-to-abortion.pdf> (accessed Feb. 4 2024).

[59] *See* Goldman et al., *Physician Assistants as Providers of Surgically Induced Abortion Services,* 94 Am. J. Pub. Health 1352, 1355-56 (2004), <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.94.8.1352?download=true> (accessed Feb. 4, 2024).

abortion care. ACOG published an opinion in December 2020 calling for the repeal of requirements that only physicians or obstetrician-gynecologists provide abortion care and stating that the literature supports that "trained advanced practice clinicians can safely provide abortion services."[60] The American Public Health Association issued a Policy Statement in 2011 stating, "[t]here is evidence that with appropriate education and training, NPs, CNMs, and PAs can competently provide all components of medication abortion care (pregnancy testing counseling, estimating gestational age by exam and ultrasound, medical screening, administering medications, and postabortion follow-up care)[.]"[61] It recommended that APCs be engaged in the provision of early abortions and that scope-of-practice regulations should align with this recommendation.[62] The World Health Organization similarly recommends that medication abortion be managed by "traditional and complementary medicine professionals, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners" as well as community health workers, pharmacy workers, and patients themselves.[63] The National Academies concluded based on extensive research that a wide array of clinicians, including APCs, provide safe and effective medication and aspiration abortions consistent with training and experience. And it concluded that policies "establishing higher-level credentials than are

[60] ACOG Committee Op. 815, *supra* note 58.

[61] Am. Pub. Health Ass'n, Policy Number 20112, Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants (2011), <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/28/16/00/provision-of-abortion-care-by-advanced-practice-nurses-and-physician-assistants> (accessed Feb. 4, 2024).

[62] *Id.*

[63] World Health Organization, Abortion Care Guideline, at xxxii (2022), <https://apps.who.int/iris/rest/bitstreams/1394380/retrieve> (accessed Feb. 4, 2024).

necessary" thereby "reduce the availability of providers" and result in "inequitable access" to care, "limit patient preferences," "impact[] patient-centered care," and reduce "efficiency of care."[64]

100. There is no logical reason—let alone any reason related to patient health—to prevent APCs in Michigan from providing early abortion care consistent with their training and experience. In Michigan, APCs manage early miscarriages with *the very same techniques* they could use for patients seeking abortion. APCs' prescriptive authority includes risky controlled substances. Some APCs also provide far more complex care than abortion—CNMs provide obstetrical care, for example, and childbirth is far more dangerous than any method of abortion.[65]

101. While failing to advance patient health in any way, the Provider Ban contributes to logistical barriers by reducing the availability of abortion care. As mentioned above, as of 2022, 87% of Michigan counties had no abortion clinic. Over one-third of Michigan women and people of reproductive age live in these counties.[66] This deficiency is particularly dire in the predominantly rural Upper Peninsula and northeastern Lower Peninsula.[67] Because APCs are more likely to provide medical care in rural areas and other medical deserts, allowing them to provide abortions to the extent of their training and competence would likely give Michiganders more locations to obtain abortion care. Preventing qualified providers from entering the field (because the law disfavors abortion) disproportionately affects those who already struggle to access care,

[64] Nat'l Acads of Sci., Eng'g, & Med., *supra* note 1, at 118.

[65] Raymond et al., *supra* note 6, at 216.

[66] *Michigan, State Facts About Abortion*, Guttmacher Institute (2022), *see supra* note 19.

[67] *See* Donahue, *Abortion Access in Northern Michigan Is Already Limited. Restrictive Laws Make It Worse*, Mich. Advance (Jan. 30, 2022), <https://michiganadvance.com/2022/01/30/abortion-access-in-northern-michigan-is-already-limited-restrictive-laws-make-it-worse/> (accessed Feb. 4, 2024).

including Black women and other people of color, indigenous people, low-income people, and rural people. This further exacerbates the effects of poor maternity care generally. As of 2015, Michigan's 57 rural counties only had 29 hospitals providing maternity care.[68]

102. For all of these reasons, the Provider Ban violates the fundamental constitutional right to abortion enshrined in the RFFA. And because it discriminates against one form of reproductive healthcare—including by barring APCs from providing identical care to abortion patients that they already provide to miscarriage patients—the Provider Ban also violates the RFFA's prohibition on discrimination. It also discriminates because it disproportionately impacts communities of color, low-income people, rural people, and others who face systemic barriers to healthcare access. Further, the requirement harms Northland and MSFC individually by undermining the provision of evidence-based care and evidence-based medical training.

VI. CLAIMS FOR RELIEF

FIRST CLAIM FOR RELIEF
Const 1963, Art I, § 28(1) RFFA – Fundamental Constitutional Right to Abortion

103. Plaintiffs hereby re-allege and incorporate by reference paragraphs 1 through 102 above.

104. The Challenged Laws each violate Section (1) of the RFFA by denying, burdening, and infringing Michiganders' fundamental right to reproductive freedom, which encompasses the right to abortion, without medical justification, and do so by imposing requirements that are inconsistent with the standard of care and that intrude on patients' autonomous decision-making. Further, the Challenged Laws harm Northland and MSFC individually by undermining the provision of evidence-based care and evidence-based medical training.

[68] Wendling, *supra* note 20, at 567, 569.

SECOND CLAIM FOR RELIEF
Const 1963, Art I, § 28(2) RFFA – Nondiscrimination

110. Plaintiffs hereby re-allege and incorporate by reference paragraphs 1 through 102 above.

111. The Challenged Laws violate Section (2) of RFFA by discriminating in the protection and enforcement of the right to reproductive freedom in at least two ways. First, each of the Challenged Laws singles out abortion providers and people seeking abortion from their counterparts in other areas of reproductive healthcare like obstetrical care. Second, each of the Challenged Laws visits particular harms on certain Michigan communities, including Black people and other people of color, indigenous people, low-income people, and rural people.

VII. REQUEST FOR RELIEF

WHEREFORE Plaintiffs request that the Court:

A. Issue a Declaratory Judgment that the Challenged Laws are unconstitutional because they violate the RFFA;

B. Enjoin Defendants, their successors, agents, servants, employees, and attorneys, and all persons in active concert or participation with them, including all persons supervised by the Defendants, from enforcing the Challenged Laws preliminarily without bond and permanently;

C. Grant such other and further relief as this Court deems just, proper, and equitable, including an award of costs and attorney's fees to Plaintiffs.

Respectfully submitted, this 6th day of February,

/s/David A. Moran

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**Pro Hac Vice* Applications Forthcoming

COUNSEL FOR PLAINTIFFS

STATE OF MICHIGAN
IN THE COURT OF CLAIMS

NORTHLAND FAMILY PLANNING CENTER, on behalf of itself, its staff, its clinicians, and its patients; **NORTHLAND FAMILY PLANNING CENTER INC. EAST**, on behalf of itself, its staff, its clinicians, and its patients; **NORTHLAND FAMILY PLANNING CENTER INC. WEST**, on behalf of itself, its staff, its clinicians, and its patients; and **MEDICAL STUDENTS FOR CHOICE**, on behalf of itself, its members, and its members' patients,

Plaintiffs,
v.

DANA NESSEL, Attorney General of the State of Michigan; **MARLON I. BROWN**, Acting Director of Michigan Licensing and Regulatory Affairs; and **ELIZABETH HERTEL**, Director of the Michigan Department of Health and Human Services, each in their official capacities, as well as their employees, agents, and successors,

Defendants.

Case No.

Hon.

This case involves a claim that a statute is unconstitutional.

VERIFIED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

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VERIFIED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

There is no other civil action between these parties arising out of the same transaction or occurrence as alleged in this complaint pending in this court, nor has such action been previously filed and dismissed or transferred after having been assigned to a judge, nor do I know of any other civil action, now between these parties, arising out of the same transaction or occurrence as alleged in this complaint that is either pending or was previously filed and dismissed, transferred, or otherwise disposed of after having been assigned to a judge in this court.

/s/ David A. Moran
David A. Moran
MI Bar #P45353

Plaintiffs Northland Family Planning Center, Northland Family Planning Center Inc. East, and Northland Family Planning Center Inc. West (collectively, "Northland"), each on behalf of itself, its clinicians, its staff, and its patients, and Medical Students for Choice ("MSFC"), on behalf of itself, its members, and its members' patients, by and through their undersigned attorneys, bring this Complaint for declaratory and injunctive relief against the above-named Defendants, their employees, agents, and successors in office and in support thereof state the following:

I. PRELIMINARY STATEMENT

1. Michiganders have a fundamental right to abortion guaranteed by their state constitution. Pursuant to this right, Michiganders seeking abortion must be free from medically unjustified laws denying, burdening, or infringing their decision to have an abortion. Further, Michiganders must be free of discrimination in the enforcement or protection of this constitutional right. In this case, abortion providers and advocates challenge three abortion restrictions that run roughshod over these constitutional guarantees.

2. On November 8, 2022, following the United States Supreme Court's decision to reverse 50 years of precedent protecting a federal right to abortion, the people of Michigan voted to enact the Reproductive Freedom For All Amendment (the "RFFA"). Const 1963, art I, § 28. The RFFA amended the Michigan Constitution to protect an individual's "fundamental right to reproductive freedom," including an individual's decision about whether to have an abortion, subject to strict scrutiny. *Id.* § 28(1). As a result, Michigan cannot enact laws that "den[y], burde[n]," or "infringe[]" the individual's right to abortion without demonstrating that such laws serve a compelling interest achieved by the least restrictive means. *Id.* The *only* compelling interest the State can assert under the RFFA is the "limited purpose of protecting the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine." *Id.* § 28(4). The RFFA explicitly dictates that the State can *never* advance a compelling state interest in patient health via means that intrude "on [an] individual's autonomous decision-making." *Id.*

3. In addition to this substantive fundamental liberty, the RFFA also explicitly prohibits "discriminat[ion] in the protection or enforcement of this fundamental right," § 28(2), such that restrictions on reproductive freedom cannot stand if they privilege some reproductive choices over others, including by subjecting abortion to unique restrictions not applicable to other pregnancy care. Restrictions on abortion also cannot disproportionately harm certain groups, such as Black, indigenous, and other people of color. This nondiscrimination clause is broad on its face. Consistent with Michigan's civil rights traditions, discrimination on the basis of religion, race, color, national origin, age, sex, sexual orientation, gender identity or expression, height, weight, familial status, or marital status is impermissible under the RFFA's nondiscrimination clause.

4. This action for declaratory and injunctive relief challenges the constitutionality of three Michigan abortion restrictions that provide no health benefit whatsoever, undermine the standard of care, and interfere with patients' autonomous decision-making—the 24-Hour Delay, Mandatory Biased Counseling, and Provider Ban (collectively the "Challenged Laws"), set forth at MCL 333.17015 (attached hereto as Exhibit A) and 333.17015a (attached hereto as Exhibit B).

5. The 24-Hour Delay and Mandatory Biased Counseling were designed to pressure Michiganders into choosing continuing a pregnancy over abortion. They force patients to needlessly delay time-sensitive abortion care and impose logistical barriers. They also force patients to consume uniform information encouraging them to continue a pregnancy—much of which is irrelevant, misleading, and/or stigmatizing—regardless of their individual needs and circumstances. As a result, the 24-Hour Delay and Mandatory Biased Counseling actually *thwart* true informed consent and autonomous healthcare decision-making, which are inherently individualized and centered around a patient's autonomy.

6. For the same reasons, these laws are contrary to the standard of care. These requirements plainly violate Michiganders' right to abortion because they lack any medical justification, are inconsistent "with accepted clinical standards of practice and evidence-based medicine," and *intentionally* interfere with an "individual's autonomous decision-making." Const 1963, art 1 § 28(4). These requirements also perpetuate the false idea that pregnant Michiganders need the State's paternalistic intervention. Michiganders have now stated through the RFFA, in the most forthright terms, that they do not need the State to help them decide what healthcare is best for them. They do not need to consume boiler-plate ideological materials or experience a forced delay in order to make their own healthcare decisions.

7. The Provider Ban, which prohibits anyone other than a physician from providing abortions, is similarly a clear violation of the individual's fundamental right to abortion. Robust research and provider experience in numerous states demonstrates that Advanced Practice Clinicians ("APCs") like Certified Nurse Midwives ("CNMs"), Nurse Practitioners ("NPs"), and Physician Assistants/Associates ("PAs") provide abortion care in early pregnancy as safely and effectively as physicians. Excluding them from providing this care serves no one, and it restricts the availability of this essential and constitutionally protected healthcare for patients. As a result, the Provider Ban also infringes Michiganders' ability to choose abortion without medical justification, is inconsistent with the standard of care, and burdens patients' decision-making by restricting access to clinicians. Michiganders are constitutionally entitled to have access to abortion that is not limited by useless restrictions on qualified clinicians.

8. For all of these reasons, all mainstream medical professional institutions that have weighed in on the provision of abortion care in the United States have concluded that laws like those challenged here—mandatory waiting periods, biased counseling provisions, and provider restrictions—have no medical basis, are out of line with the standard of care, and intrude on autonomous decision-making, thereby significantly harming patients. For example, in its comprehensive report on the safety and quality of abortion care in the United States, the National Academies of Sciences, Engineering, and Medicine concluded: "[t]he clinical evidence . . . on the provision of safe and high-quality abortion care *stands in contrast to* the extensive regulatory requirements that state laws impose on the provision of abortion services," including laws that "misinform women of the risks of the procedures they are considering, overrule women's and

clinician's medical decision making, or require medically unnecessary services and delays in care" and those that restrict "provider type" and "provider training."[1]

9. Because the Challenged Laws are inconsistent with the standard of care, they also interfere with the best abortion training, requiring medical students and residents in Michigan to learn to provide abortion care in a legal context that does not best support their practice or patient wellbeing.

10. Only people who seek abortion are subject to the Challenged Laws; not patients seeking any other form of reproductive healthcare or any other form of healthcare, period. Thus, the Challenged Laws also violate the RFFA's nondiscrimination provision by singling out abortion care and abortion patients for unnecessary and harmful regulation.

11. The Challenged Laws are also discriminatory because particular groups of Michiganders bear the brunt of these restrictions, including Black people, indigenous people, low-income people, and rural people.

12. Prior to Michigan voters making their voices heard through the RFFA, the Michigan Legislature piled on restriction after restriction on abortion over the decades following *Roe v Wade*, including medically unjustified facility regulations and the Challenged Laws. The RFFA has rendered these laws plainly unconstitutional. In light of this, the Michigan Legislature enacted a series of bills known as the Reproductive Health Act to repeal many of those restrictions that the Legislature recognized were no longer consistent with the Michigan Constitution. That bill package included the Challenged Laws, until they were omitted at the eleventh hour, despite the fact that they are among the most baseless and harmful restrictions. Once it became clear that the

[1] Nat'l Acads. of Sci., Eng'g, & Med., *The Safety and Quality of Abortion Care in the United States* 11, 77, 163 (Mar. 16, 2018), <https://nap.nationalacademies.org/cart/download.cgi?record_id=24950> (accessed Feb. 4, 2024) (emphasis added).

Legislature was not repealing the Challenged Laws, despite the RFFA, Plaintiffs prepared this lawsuit expeditiously to vindicate the full scope of Michiganders' constitutional rights.

II. JURISDICTION

13. This Court has jurisdiction over this action pursuant to MCL 600.6419(1)(a), which gives the Court of Claims jurisdiction "[t]o hear and determine any claim or demand, statutory or constitutional . . . or any demand for monetary, equitable, or declaratory relief or any demand for an extraordinary writ against the state or any of its departments or officers notwithstanding another law that confers jurisdiction of the case in the circuit court."

14. Plaintiffs' action for declaratory and injunctive relief is authorized by MCR 2.605 and 3.310, and by the general legal and equitable powers of this Court.

III. PARTIES

A. Plaintiffs

a. Northland

15. Northland operates some of the finest outpatient healthcare facilities in the nation. Northland has provided high quality abortion care since 1976.

16. Northland has three reproductive healthcare clinics located in Southfield, Oakland County; Sterling Heights, Macomb County; and Westland, Wayne County. Each location provides medication abortion up to 11 weeks (dated from the pregnant individual's last menstrual period, or "LMP"), and procedural abortion up to 24 weeks LMP.[2]

[2] To preserve accuracy, this complaint uses the terms "woman," "women," "she," or "her" whenever sources categorize people that way. However, Plaintiffs note that people with other gender identities, including transgender men and gender-diverse individuals, may also become pregnant and seek abortion services.

17. Northland regularly trains Obstetrics and Gynecology ("OB/GYN") and Family Medicine residents, OB/GYN fellows, and medical students to provide abortion care. At present, Northland has fellows in rotation.

18. Northland is required to abide by the Challenged Laws, and its clinicians, staff, and patients are harmed by their impact. This is particularly true for the majority of their patients who are people of color and the vast majority who are low income.

b. MSFC

19. MSFC is a 501(c)(3) non-profit organization whose mission is to train tomorrow's abortion providers and pro-choice physicians. MSFC assists medical students and residents to maintain patient access to abortion and family planning education and training, including through curriculum reform, training in a clinic setting, abortion training institutes, and MSFC's two-day annual conference for family planning. MSFC is devoted to expanding access to health services that allow patients to lead safe, healthy lives consistent with their own personal and cultural values, with respect to all aspects of sexual and reproductive health.

20. MSFC has had chapters in Michigan for 25 years. It currently has active chapters at: Central Michigan University College of Medicine, Michigan State University College of Human Medicine East Lansing, Michigan State University College of Human Medicine Grand Rapids, Oakland University William Beaumont School of Medicine, University of Michigan Medical School, Wayne State University School of Medicine, and Western Michigan University Homer Stryker M.D. School of Medicine. Currently, there are approximately 361 MSFC members enrolled in Michigan's medical schools.

21. In the United States, MSFC offers multiple abortion training programs that provide its members with financial and logistical support to receive abortion and family planning training.

First, the Reproductive Health Externship Funding Program provides members with financial support to receive clinical training in abortion care outside of their institution's standard curriculum by spending two to four weeks in a clinic of their choice. Second, the Clinical Abortion Observation program offers members the opportunity to spend anywhere from three to nine days in a clinical setting receiving training in abortion care. Third, MSFC's Abortion Training Institute is an intensive two-day educational opportunity for members to learn about abortion and family planning in a small-group conference setting. In the last decade, 2,350 students have been trained through these programs, around 37 of them from Michigan schools, and 5 of the trainings occurred in Michigan. MSFC members in Michigan coordinate with local organizations on the ground that offer logistical and financial support to pregnant people seeking abortion, and with organizations that advocate for policy changes to improve the reproductive health of Michiganders. MSFC also supports residents through the Training to Competence Externship funding program, which provides medical residents with financial and logistical support for receiving clinical abortion training outside of their program's standard curriculum.

22. MSFC members learn how to provide abortion care and counsel patients in a holistic fashion, including how to obtain individualized informed consent. In addition, MSFC members in Michigan are trained to treat patients, especially those from underserved communities, with compassion, care, and cultural literacy.

23. MSFC's members training in Michigan are harmed by restrictions on abortion care that undermine the standard of care and create health inequities in reproductive health as are their patients. MSFC must make up the difference in training when their members are exposed to training environments that are inconsistent with the best evidence-based medicine.

B. Defendants

24. Defendant Dana Nessel is the Attorney General of Michigan. She is responsible for defending Michigan laws against constitutional challenges. MCL 14.28-14.30; Const 1963, art 5, §§ 1, 3. The Attorney General also acts in a representative and advisory capacity with respect to Michigan administrative agencies, including the Michigan Department of Licensing and Regulatory Affairs ("LARA"). The Michigan Attorney General is sued in her official capacity, as are her agents and successors.

25. Defendant Marlon I. Brown is the Acting Director of LARA. Defendant Brown is sued in his official capacity, as are his agents and successors.

26. Elizabeth Hertel is the Director of the Michigan Department of Health and Human Services. Defendant Hertel is sued in her official capacity, as are her agents and successors.

IV. THE RFFA

27. The constitutional protections afforded by the RFFA form a powerful bulwark against medically unjustified government intrusion and discrimination that confers broad protections for individual reproductive freedom and equality.

28. The RFFA passed with overwhelming support from the people of Michigan. It is among the most robust protections for reproductive freedom in the nation.

29. Under the RFFA, "[e]very individual has a fundamental right to reproductive freedom, which entails the right to make and effectuate decisions about all matters relating to pregnancy, including but not limited to prenatal care, childbirth, postpartum care, contraception, sterilization, abortion care, miscarriage management, and infertility care," and "[t]he state shall not discriminate in the protection or enforcement of this fundamental right." Const 1963, art I, § 28 (1), (2).

30. The RFFA demands that "[a]n individual's right to reproductive freedom shall not be denied, burdened, nor infringed upon unless justified by a compelling state interest achieved by the least restrictive means." Const 1963, art I, § 28 (1). The RFFA specifically defines a state interest as compelling "only if it is for the limited purpose of protecting the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine, and does not infringe on that individual's autonomous decision-making." *Id.* § 28 (4).

31. Further, because the RFFA also prohibits "discriminat[ion] in the protection or enforcement" of the fundamental right to reproductive freedom, abortion restrictions cannot single out abortion for discriminatory treatment or disproportionately harm certain groups, such as protected classes.

V. FACTUAL BACKGROUND

A. Abortion is extraordinarily safe, common, and an essential component of pregnancy care.

32. Abortion is one of the safest medical procedures performed in the United States.[3] Leading medical authorities, including the American College of Obstetricians and Gynecologists ("ACOG"), the American Medical Association ("AMA"), the National Academies, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association, have all concluded that abortion is one of the safest procedures in contemporary medical practice. In its comprehensive report, the National Academies concluded

[3] Nat'l Acads of Sci., Eng'g, & Med., *supra* note 1, at 163–65; *Whole Woman's Health v. Hellerstedt*, 579 U.S. 582, 617–19; 136 S.Ct. 2292, 2315-2316 (2016) (recognizing abortion as a safe procedure with low risk of complications), *abrogated on other grounds by Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 142 S. Ct. 2228 (2022).

that aspiration and medication abortions "rarely result in complications" and do so at rates of "no more than a fraction of a percent."[4]

33. By comparison, vasectomy, a procedure that, like abortion, is frequently performed in a physician's office as a part of reproductive healthcare, has a two percent complication rate, more than double that of abortion.

34. In the first trimester of pregnancy, abortions are performed via medication or procedure. Medication abortion is generally available through 11 weeks LMP. Medication abortion is administered orally, typically with two medications. Patients take the first medication, mifepristone, which stops the pregnancy from growing, and then a second medication, misoprostol, up to 48 hours later, which allows patients to pass the contents of the uterus in a process similar to a miscarriage. Medication abortion is comparable in safety to ibuprofen and acetaminophen.[5]

35. Abortion by procedure in early pregnancy is performed by aspiration, also referred to as "suction curettage." This is a straightforward outpatient procedure through which a clinician removes the contents of the uterus with gentle suction. Procedural abortion is sometimes referred to as "surgical" abortion, although no incision is made. Because there is no incision and instruments are introduced through a body cavity, aspiration abortion does not need to be performed in a sterile operating room. Nor does an aspiration procedure require general anesthesia. The procedure typically takes about five to ten minutes.

36. Starting around 14 weeks LMP, clinicians use forceps or other instruments in addition to gentle suction to remove the contents of the uterus, a procedure known as dilation and

[4] Nat'l Acads of Sci., Eng'g, & Med., *supra* note 1, at 55, 60.

[5] *Id.* at 79.

evacuation or "D&E." Because of its impressive safety record and simplicity, D&E procedures are the most commonly used method of abortion after 14 weeks LMP. D&E is a quick procedure, typically lasting under 10 minutes. Depending on the patient and the method of cervical preparation, abortion providers can perform D&E as a one or two-day procedure. D&E is routinely and safely provided in outpatient, office-based settings nationwide, and generally involves no more than moderate sedation. D&E also requires no incision.

37. The very same medications and procedures used in the context of abortion are used to treat patients experiencing a miscarriage.

38. Induction abortion is the only medically proven alternative to aspiration abortion and D&E available throughout the second trimester. As the name implies, induction abortion involves medications that cause the uterus to contract and the patient to undergo labor. Second trimester induction abortions are very uncommon in the United States because they usually take place in hospitals or similar facilities, last between 8 and 36 hours, and entail contractions and the process of labor, which can be painful and require strong medications, sedatives, or anesthesia. There is also a significant cost difference between an inpatient procedure requiring multiple days of hospitalization and an outpatient procedure such as a D&E.

39. Abortion is far safer than carrying a pregnancy to term, and it has an exceptionally low rate of complication. The risk of mortality of childbirth is 14 times higher than that associated with abortion.[6] Pregnancy complications are also extremely common. They include preeclampsia, a condition that impacts the brain, kidneys, heart, and lungs, and can lead to stroke, seizure, kidney

[6] Raymond et al., *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetric Gynecology 215, 215–19 (Feb. 2012), <http://unmfamilyplanning.pbworks.com/w/file/fetch/119312553/Raymond%20et%20al-Comparative%20Safety.pdf> (accessed Feb. 4, 2024).

failure, liver failure, and hemorrhage. There are numerous maternal conditions that pose a substantial mortality risk in pregnancy, including pulmonary hypertension and maternal cardiac disease, some with mortality risks as high as 50 percent.[7] Many pregnant individuals suffer from gestational diabetes, cardiovascular risk factors, or hypertension and preeclampsia, and these conditions disproportionately impact Black women and other people of color.[8] Pregnancy can also exacerbate mental health conditions, including during the post-partum period.

40. Most people who access abortion care are living in poverty, making up around 75% of people who have abortions due to systemic inequities in health and healthcare access.[9] A large majority of Northland's patients qualify for some kind of financial assistance.

41. People seeking an abortion do so for a wide variety of personal reasons, including familial, medical, and financial reasons. Nearly one in four women in the United States will have had an abortion by the time they are 45 years old.[10]

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[7] Minhas et al., *Racial Disparities in Cardiovascular Complications with Pregnancy-Induced Hypertension in the United States*, 78 Hypertension 480–88 (Aug. 2021), <https://www.ahajournals.org/doi/epub/10.1161/HYPERTENSIONAHA.121.17104> (accessed Feb. 4, 2024).

[8] *Id.*; Bornstein et al., *Racial Disparity in Pregnancy Risks and Complications in the US: Temporal Changes during 2007–2018*, J. Clinical Med., vol. 9, art. No. 1414, at 3–9 (May 2020), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7290488/pdf/jcm-09-01414.pdf> (accessed Feb. 4, 2024).

[9] Jerman et al., *Barriers to Abortion Care and Their Consequences for Patients Traveling for Services: Qualitative Findings from Two States*, 49 Perspectives on Sexual & Reprod. Health (2017), 95–102, <https://www.guttmacher.org/sites/default/files/research_article/file_attachments/4909517.pdf> (accessed Feb. 4, 2024).

[10] Guttmacher Inst, *Induced Abortion in the United States*, <https://www.guttmacher.org/sites/default/files/factsheet/fb_induced_abortion.pdf> (accessed Feb. 4, 2024).

42. People of all religious faiths have abortions: 24% are Roman Catholics; 17% are mainline Protestants; 13% are evangelical Protestants; and 8% belong to other faith traditions.[11]

43. Most abortion patients already have children. Nationally, three-fourths of abortion patients cite responsibility to other individuals (such as children or elderly parents) as a reason for terminating their pregnancy. Many also say they cannot afford to become a parent or to add to their families, and that having a child would interfere with work, school, or the ability to care for dependents.

44. Other abortion patients are experiencing intimate partner violence and may face additional threats to their safety and wellbeing if their partner becomes aware of their pregnancy or desire to obtain an abortion; many such patients fear that being forced to carry a pregnancy to term would further tether them to their abusers. Studies show that women who carry an unwanted pregnancy to term are less likely to leave an abusive relationship because of that connection to their abuser.[12]

45. Some patients seek abortions because they have become pregnant as a result of rape or incest.

46. Some patients decide to have an abortion because their pregnancy has been diagnosed with a condition that means even if a baby is delivered, it would never be healthy enough

[11] *Id.*

[12] Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, BMC Med., 12(144), 5–6 (2014), < https://bmcmedicine.biomedcentral.com/counter/pdf/10.1186/s12916-014-0144-z.pdf > (accessed Feb. 4, 2024); Advancing New Standards in Reprod. Health, *Fact Sheet: The Harms of Denying a Woman a Wanted Abortion* (Apr. 2020) (hereinafter "*Harms of Denying Abortion*"), <https://www.ansirh.org/sites/default/files/publications/files/the_harms_of_denying_a_woman_a_wanted_abortion_4-16-2020.pdf> (accessed Feb. 4, 2024).

to go home. Some abortion patients with high-risk pregnancies have complications that lead them to end their pregnancies to preserve their own life or health.[13]

47. Whatever a patient's reason, accessing abortion is essential to their autonomy, dignity, and ability to care for themselves and their families. Becoming a parent against one's will leads to worse psychological, physical, and economic outcomes than those of pregnant people who are able to access wanted abortion care. A person forced into parenthood is more likely to experience poverty, health difficulties, and physical violence, as are their families.[14] Studies show worse child development outcomes for children of women who have been denied an abortion, and children born out of abortion denial are more likely to live below the federal poverty guidelines compared to children born from a subsequent pregnancy to women who received a wanted abortion.[15]

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[13] Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, Perspectives on Sexual and Reproductive Health 110, 114–16 (2005), <https://www.guttmacher.org/sites/default/files/article_files/3711005.pdf> (accessed Feb. 4, 2024).

[14] Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 Am. J. Pub. Health 407 (2018), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5803812/pdf/AJPH.2017.304247.pdf> (accessed Feb. 4, 2024) (finding "women denied an abortion were more likely than were women who received an abortion to experience economic hardship and insecurity lasting years"); Ralph et al., *Self-Reported Physical Health of Women Who Did and Did Not Terminate Pregnancy After Seeking Abortion Services: A Cohort Study*, 171 Annals Internal Med. 238, 243-45 (2019) (concluding "differences emerged suggesting worse health among those who gave birth" after being denied an abortion than those who underwent abortion) <https://pubmed.ncbi.nlm.nih.gov/31181576/> (accessed Feb. 5, 2024).

[15] Foster et al., *Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children*, 205 J. Ped. 183–89 (2019), <https://www.jpeds.com/action/showPdf?pii=S0022-3476%2818%2931297-6> (accessed Feb. 4, 2024); 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 JAMA Ped. 1053–1060 (2018), <https://jamanetwork.com/journals/jamapediatrics/fullarticle/2698454> (accessed Feb. 4, 2024).

48. In sum, access to abortion is an essential component of comprehensive healthcare, and it is key to facilitating equal participation in society of pregnant Michiganders, including in the economic and social fabric of Michigan. Michiganders must be able to make autonomous personal decisions about whether and when to have children, and they have now enshrined that right in the broadest terms in their state constitution.

B. Michigan law singles out abortion from other reproductive healthcare for uniquely discriminatory treatment.

49. Abortion is subject to restrictions inapplicable to any other form of healthcare provided in Michigan.

50. Decades of legislation siloed abortion from all other areas of medicine in the state. In 1988, the anti-abortion organization Right to Life of Michigan led citizen petition drives that prohibited Medicaid funding for abortion, MCL 400.109a.

51. In 1993, the Legislature enacted the Challenged Laws.[16] Those requirements were modified repeatedly over time through litigation, settlement, and further legislation.[17]

52. In 2012, the legislature passed H.B. 5711, known as the Abortion Omnibus Bill, which consolidated 7 previously introduced bills and created onerous and unnecessary facilities requirements, among other harms.[18]

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[16] *Clarify Abortion Informed Consent: Third Analysis,* Michigan House Fiscal Agency, Dec 22, 2000, <https://www.legislature.mi.gov/documents/1999-2000/billanalysis/House/htm/1999-HLA-5548-C.htm> (accessed Feb. 4, 2024).

[17] *Id.*; *Restrict Requirement of Prepayment for Abortion: First Analysis,* House Legislative Analysis Section, May 15, 2002, <http://www.legislature.mi.gov/documents/2001-2002/billanalysis/House/pdf/2001-HLA-5971-a.pdf> (accessed Feb. 4, 2024); *Michigan's Informed Consent for Abortion Law,* MDHHS, <https://www.michigan.gov/mdhhs/adult-child-serv/informedconsent> (accessed Feb. 4, 2024).

[18] *Legislative Analysis: Abortion-Related Amendments*, House Fiscal Agency, Sept. 11, 2012, at 9, http://www.legislature.mi.gov/documents/2011-2012/billanalysis/House/pdf/2011-HLA-5711-3.pdf (accessed Feb. 4, 2024); Abortion Related Amendments Second Legislative Analysis, House

53. Piling on, in 2013, the State mandated that all abortions other than to avert a patient's death could be covered in healthcare plans only by optional riders, even in cases of rape and incest. Act 182 of 2013, codified as MCL 550.541-550.551.

54. Today, while some of the harmful laws mentioned above have been repealed, the 24-Hour Delay, Mandatory Biased Counseling, and Provider Ban have not, despite the fact that they are among the most burdensome restrictions for patients and directly interfere with their access to abortion and decision-making.

55. The legislative overlay created by the Challenged Laws, applicable solely to abortion services, is unique among all other medical care in Michigan. Pregnant patients who are not seeking abortions are not similarly restrained from obtaining the pregnancy care they require. So too, no other Michiganders experience equivalent barriers when seeking any other comprehensive reproductive or other health care—even services that are not constitutionally protected. Only pregnant individuals, and specifically those seeking abortions, are singled out in this way.

56. No other patients are forced to delay essential and time-sensitive healthcare or forced to consume non-individualized, irrelevant, and stigmatizing information. The State does not attempt to dissuade other people seeking healthcare from choosing care that is best for them. In no other area of healthcare are qualified trained clinicians specifically barred from providing services consistent with their training and experience. There is nothing like the Challenged Laws anywhere else in Michigan's regulation of healthcare and for obvious reason. Abortion was singled out because of opposition to it and for no health-related reason at all.

Fiscal Agency, Feb 14, 2013, at 14-25, <https://www.legislature.mi.gov/documents/2011-2012/billanalysis/House/pdf/2011-HLA-5711-28C443C7.pdf> (accessed Feb. 4, 2024).

57. These restrictions also promote stereotyped notions that motherhood is the preferred, natural, and proper state for Michiganders who become pregnant, and that they are not capable of making decisions about the timing, number, and spacing of children, but rather must be protected from the consequences of making decisions others see as wrong. They also reflect the blatant falsehood that abortion is unsafe when it is among the safest healthcare available in the U.S.

C. Restricting access to abortion disproportionately harms communities of color and other people facing systemic barriers to healthcare access.

58. There are significant disparities in access to abortion nationally and in Michigan, specifically. People who already face significant barriers to healthcare access, including Black women and other people of color, indigenous people, people living on low incomes, and rural people, face disproportionate barriers in accessing abortion. These disparities are particularly significant in Michigan because of the challenges these communities have historically faced in the state.

59. About 87% of Michigan counties have no abortion clinics, but over one-third of Michiganders of reproductive capacity live in these counties.[19]

60. Michigan has large rural areas that make transportation difficult. The Upper Peninsula and northeastern Lower Peninsula do not contain a single urban county.[20]

61. Traveling to an abortion clinic may pose extreme difficulties for people of color, indigenous people, low-income people, and rural people who lack access to public transportation or their own household vehicle. Around 18% of Black households in Michigan do not have access

[19] *State Facts About Abortion: Michigan*, Guttmacher Inst (2022), <https://www.guttmacher.org/sites/default/files/factsheet/sfaa-mi.pdf> (accessed Feb. 4, 2024).

[20] Wendling et al., *Access to Maternity and Prenatal Care Services in Rural Michigan*, 48 Birth 566, 567 (Dec. 2021), <https://onlinelibrary.wiley.com/doi/epdf/10.1111/birt.12563> (accessed Feb. 4, 2024).

to a car.[21] In addition, low-income people and people of color already live in public transit deserts. "Michiganders who take public transportation spend an extra 67.7% of their time commuting and non-White households are 5.6 times more likely to commute via public transportation. 17% of trains and other transit vehicles in the state are past useful life."[22] Research consistently shows that access to abortion care is sensitive to increases in logistical burdens—even small increases in travel distance or congestion at abortion facilities due to reduced access can stop people from getting care and force them to carry an unwanted pregnancy to term.[23]

62. Struggling families in Michigan also do not have adequate access to general healthcare, prenatal and post-natal care, parental leave, childcare, lactation support, and

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[21] *Summary Data Brief of the Changes in Health Disparities Between 2018-2020* (hereinafter "*Health Disparities*"), at 2, Michigan Dep't Health & Human Servs., <https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Keeping-Michigan-Healthy/Chronic-Disease/OEMH/Summary_Data_Brief_of_the_Changes_in_Health_Disparities_Between_2018-2020.pdf?rev=0dced0bfcf0a42d3818b8ab50be82965&hash=39117B5A95BA0A20AD37D082A8550332> (accessed Feb. 4, 2024).

[22] *American Jobs Plan: The Need for Action in Michigan*, White House (2021), <https://www.whitehouse.gov/wp-content/uploads/2021/04/AJP-State-Fact-Sheet-MI.pdf> (accessed Feb 4, 2024).

[23] Grossman, *The Use of Public Health Evidence in Whole Woman's Health v Hellerstedt*, 177 JAMA Internal Med. 155-56 (2017) <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2580725> (accessed February 5, 2024); Lindo et al., *How Far Is Too Far? New Evidence on Abortion Clinic Closures, Access, and Abortions*, 55 J. Hum. Res. 1137 (2020) <https://jhr.uwpress.org/content/55/4/1137> (accessed Feb. 5, 2024); Quast et al., *Abortion Facility Closings and Abortion Rates in Texas*, 54 Inquiry 1 (2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5798726/pdf/10.1177_0046958017700944.pdf> (accessed Feb. 4, 2024); 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 (2018) <https://www.nber.org/papers/w23634> (accessed Feb. 5, 2024); Venator et al., *Undue Burden Beyond Texas: An Analysis of Abortion Clinic Closures, Births, and Abortions in Wisconsin*, 40 J. Pol'y Analysis & Mgmt. 774 (2020), <https://onlinelibrary.wiley.com/doi/epdf/10.1002/pam.22263> (accessed Feb. 4, 2024).

accommodations for disabilities. In Michigan, more women than men are impoverished.[24] Moreover, a large proportion of these struggling families are Black. Between 2018 and 2020, 35% of Black Michiganders lived in poverty, more than twice the overall Michigan poverty rate and far higher than the national Black poverty rate (20.8%).[25]

63. In Michigan, more than half of abortion patients are Black.[26] The majority of Northland's patients are Black women or other people of color. That abortion restrictions fall hardest on communities of color is no accident. Abortion restrictions are part and parcel of America's history of reproductive and sexual control policies targeting pregnant individuals, especially Black and indigenous women. Reproductive control policies have been used to systematically deprive pregnant individuals of the liberty to make decisions about when, whether, and under what conditions to birth and raise children. These state-sanctioned policies have included enslavement and forced birth, the removal of children from their families and cultures, sterilization, and contraception and abortion restrictions.[27] The impact of these harms over time

[24] *Status of Women in the States*, Institute for Women's Policy Research (2018), <https://statusofwomendata.org/wp-content/themes/witsfull/factsheets/economics/factsheet-michigan.pdf> (accessed Feb. 4, 2024).

[25] *Health Disparities*, *supra* 21note 21, at 2; *Historical Poverty Table 2: Poverty Status of People by Family Relationship, Race, and Hispanic Origin* – 1959 to 2022, U.S. Census Bur. (Sep. 12, 2023), <https://www2.census.gov/programs-surveys/cps/tables/time-series/historical-poverty-people/hstpov2.xlsx> (accessed Feb. 4, 2024).

[26] *Table 11: Number and Percent of Reported Induced Abortions by Race or Hispanic Ancestry of Woman, Michigan Residents, 2022*, Mich. Dep't Comm'y Health (2022), <https://www.mdch.state.mi.us/osr/abortion/Abortrace.asp#> (accessed Feb. 4, 2024).

[27] *See, e.g.*, Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (1997); Stern, *Forced Sterilization Policies in the US Targeted Minorities and Those with Disabilities – and Lasted Into the 21st Century*, U. Mich. Inst. For Healthcare Policy & Innovation (Sept. 23, 2020), <https://web.archive.org/web/20201201185614/https://ihpi.umich.edu/news/forced-sterilization-policies-us-targeted-minorities-and-those-disabilities-and-lasted-21st> (accessed Feb. 4, 2024).

can be felt in today's entrenched inequities in health and access to healthcare. As a result, today's abortion restrictions cut deepest into communities that have suffered generations of reproductive coercion and discrimination.

64. One of the most devastating manifestations of these inequities is the maternal health crisis affecting Black women and other people of color. Forcing these communities to experience unnecessary burdens and delays in accessing reproductive healthcare or to carry unwanted pregnancies perpetuates systemic discrimination by worsening the maternal mortality crisis and exacerbating racial health disparities. According to a recent report by the World Health Organization, our country is one of only 13 countries worldwide with a rising maternal mortality rate and is the only country with an advanced economy where the rate is worsening.[28] In Michigan, maternal mortality is dramatically worse for Black women than white women. Between 2014 and 2018, Black women were approximately 2.8 times more likely to die from pregnancy-related causes.[29] This racial disparity is even higher in Detroit. In general, the maternal death rate in Detroit is three times the national average. But pregnant Black women in Detroit are at even greater risk; they are 4.5 times more likely to die than white women.[30]

65. Pregnancy carries numerous risks of complications and conditions that pose a

[28] World Health Organization et al., *Trends in Maternal Mortality: 1990 to 2015: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division* (2015), at 70-77, <http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf> (accessed Feb. 3, 2024).

[29] Mich Dep't of Health & Hum Servs., *Maternal Deaths in Michigan, 2014-2018 Data Update,* at 6, <https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/MCH-Epidemiology/MMMS_2014-2018_Pub_Approved.pdf> (accessed Feb. 4, 2024).

[30] Whitaker, *Black Maternal Mortality Rate* (City of Detroit City Council Legislative Policy Division 2022), at 5, <https://detroitmi.gov/sites/detroitmi.localhost/files/2022-05/Black%20Maternal%20Mortality%20Rate%205-5-2022%20final%20-%20ST.pdf> (accessed Feb. 4, 2024).

substantial mortality risk, such as preeclampsia, pulmonary hypertension and maternal cardiac disease, some with mortality risks as high as 50 percent. These conditions affect Black women at higher rates than white women.[31]

66. Nationwide, maternal morbidity also reflects racial inequality.[32] Maternal morbidity refers to cases in which a pregnant person faces a life-threatening diagnosis or must undergo a life-saving medical procedure—like a hysterectomy, blood transfusion, or mechanical ventilation—to avoid death.[33] For every maternal death in the country, there are close to 100 cases of severe maternal morbidity.[34] Black women are twice as likely as their white counterparts to suffer severe maternal morbidity.[35] Indeed, Black women have the highest rates for 22 of 25 severe morbidity indicators used by the Center for Disease Control ("CDC").[36] Delivery through cesarean section, which carries risks of hemorrhage, infection, and injury to internal organs, is also more

[31] Minhas et al, *supra* note 7.

[32] *See* Creanga et al, *Racial and Ethnic Disparities in Severe Maternal Morbidity: A Multistate Analysis, 2008-2010,* 210 Am J Obstetrics & Gynecology 435 (2014), <https://www.ajog.org/action/showPdf?pii=S0002-9378%2813%2902153-4> (accessed Feb. 4, 2024); Admon et al., *Racial and Ethnic Disparities in the Incidence of Severe Maternal Morbidity in the United States, 2012-2015*, 132 Obstetrics & Gynecology 1158 (2018), <https://journals.lww.com/greenjournal/fulltext/2018/11000/racial_and_ethnic_disparities_in_the_incidence_of.11.aspx>.(accessed Feb. 4, 2024).

[33] Howell, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61 Clinical Obstetrics & Gynecology 387 (2018), <https://journals.lww.com/clinicalobgyn/fulltext/2018/06000/reducing_disparities_in_severe_maternal_morbidity.22.aspx> (accessed Feb. 4, 2024).

[34] *Id.*

[35] Creanga et al., *supra* note 32.

[36] Howell, *supra* note 33, at 388.

common among Black than white women.[37]

67. For people with existing medical co-morbidities, forced pregnancy results in more high-risk pregnancies and increased risk for severe maternal morbidity and mortality. Such severe maternal morbidity and mortality disproportionately affects Black women. [38]

68. Research shows that the stress of racism itself creates a "weathering" effect that may lead to poor health outcomes, including the development of chronic conditions.[39] During pregnancy, these health risks increase for Black individuals because they disproportionately face systemic racism, poverty, provider bias, and lack of access to prenatal and post-natal care.[40]

69. In addition, a person's ability to access abortion has consequences not only for that person, but also for a whole network of other people who rely on those individuals. In Michigan, two-thirds of abortion patients have already given birth, and over 40% have given birth at least

[37] Martin et al., *Birth: Final Data for 2019*, 70 Nat'l Vital Stats Report 8 (2021), <https://stacks.cdc.gov/view/cdc/100472> (accessed Feb. 4, 2024).

[38] Aziz et al*., Termination of Pregnancy as a Means to Reduce Maternal Mortality in Pregnant Women With Medical Comorbidities*, 134 Obstetrics and Gynecology 1105 (2019), <https://journals.lww.com/greenjournal/fulltext/2019/11000/termination_of_pregnancy_as_a_means_to_reduce.25.aspx> (accessed Feb. 4, 2024).

[39] Roeder, *America is Failing Its Black Mothers*, Harvard Pub. Health (2019), <https://www.hsph.harvard.edu/magazine/magazine_article/america-is-failing-its-black-mothers/> (accessed Feb. 4, 2024).

[40] *Id*.

twice. A vast number of Michigan families with children live in a single parent household—33.5%.[41] In addition, in the U.S., 16.9% of Black women provide unpaid eldercare.[42]

70. Being able to choose when and whether to be pregnant and parent a child is tied to the overall economic and social health of communities, and this is particularly so for Black communities given the structural barriers to equality they face. Restricting abortion thus impacts the ability of communities of color to advance in Michigan by inhibiting access to education and higher income employments.

VI. THE CHALLENGED LAWS VIOLATE THE RFFA

96. The Challenged Laws are comprised of two statutes that violate the RFFA by intruding on an individual's constitutional right to abortion without any justification, much less a compelling one, and doing so in discriminatory ways. MCL 333.17015, 333.17015a. The Challenged laws "den[y], burde[n]," and "infringe[]" the right to abortion without serving—*in any way*—the "limited purpose of protecting the health of an individual seeking care." Const 1963, art I, § 28. Each is "[in]consistent with accepted clinical standards of practice and evidence-based medicine." *Id.* § 28(4). And each law intrudes "on [an] individual's autonomous decision-making." *Id.* Further, they all cause significant harm to pregnant Michiganders.

97. The RFFA also prohibits "discriminat[ion] in the protection or enforcement of this fundamental right," *id.*, such that restrictions on reproductive freedom cannot stand if they privilege some reproductive choices over others, including by subjecting abortion to unique

[41] Mich. League for Pub Pol'y, *2021 Kids Count in Michigan Data Book*, at 35, <https://mlpp.org/wp-content/uploads/2021/06/2021-kids-count-in-michigan-data-book.pdf> (accessed Feb. 4, 2024).

[42] US Bureau of Lab Stats, *Unpaid Eldercare in the United States News Release*, <https://www.bls.gov/news.release/elcare.htm> (accessed Feb. 4, 2024).

restrictions not applicable to other pregnancy care. Restrictions on abortion also cannot disproportionately harm certain groups, such as Black women and other people of color.

A. The 24-Hour Delay

65. The 24-Hour Delay forces patients to wait a minimum of 24 hours after receiving the Mandatory Biased Counseling before they can obtain an abortion. Far from benefiting patients, delay pushes patients seeking abortion care to obtain that care later in pregnancy or, in some cases, not at all. Moreover, because the 24-Hour Delay causes patients to delay care, providers in Michigan are prevented from encountering patients in the best position for care and from providing abortion care that is timely and medically and scientifically indicated.

66. The majority of patients meet the requirements to trigger the 24-hour delay period by accessing a website maintained and operated by the Michigan Department of Health and Human Services. The website requires that a patient read and click through several pages of information—on the procedure, on gestational age and fetal development, and on prenatal care and parenting—which then prompts the patient to sign an acknowledgement and consent form. MCL 333.17015(5).

67. Patients who access the website are required to print a "confirmation form from the website that the patient has reviewed" this information "at least 24 hours before an abortion being performed on the patient" and "supply the valid confirmation" to the provider. MCL 333.17015(5). This printing requirement, itself, imposes extra burdens on abortion patients.

68. Mandatory delay periods like Michigan's are purportedly justified on the basis that they help patients be more certain about their decision to have an abortion and prevent regret and

mental health harms.[43] Indeed, § 333.7015 requires the Michigan Department of Health and Human Services to create materials that inform patients of risks of "depression" and "feelings of guilt." MCL 333.17015(11)(b)(iii). But a robust body of research demonstrates that most women seeking an abortion in the United States are already certain of their decision by the time they present for care and that mandatory delays do not improve certainty.[44] Further, decades of empirical research looking at the effects of abortion on women's mental health have found that there is no evidence that safe, legal abortion care harms a woman's mental health, whether due to regret or anything else.[45]

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[43] Jovel et al., *Abortion Waiting Periods and Decision Certainty Among People Searching Online for Abortion Care*, Obstetrics and Gynecology, 137(4): 597-605 (2021), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7984762/pdf/ong-137-597.pdf> (accessed Feb. 4, 2024).

[44] Ralph et al., *The Impact of a Parental Notification Requirement on Illinois Minors' Access to and Decision-Making Around Abortion*, Journal of Adolescent Health, 62(3): 281-287 (2018) <https://pubmed.ncbi.nlm.nih.gov/29248391/> (accessed Feb. 5, 2024); Ralph et al., *Measuring Decisional Certainty Among Women Seeking Abortion*, Contraception, 95: 268-278 (2017) <https://pubmed.ncbi.nlm.nih.gov/27745910/> (accessed Feb. 5, 2024); Roberts et al., *Do 72-Hour Waiting Periods and Two-Visit Requirements for Abortion Affect Women's Certainty? A Prospective Cohort Study*, Women's Health Issues, 27(4): 400-406 (2017) <https://pubmed.ncbi.nlm.nih.gov/28391971/> (accessed Feb. 5, 2024); Roberts et al., *Utah's 72-Hour Waiting Period for Abortion: Experiences Among a Clinic-Based Sample of Women*, Perspectives on Sexual and Reproductive Health, 48(4): 179-187 (2016) <https://onlinelibrary.wiley.com/doi/epdf/10.1363/48e8216> (accessed Feb. 4, 2024); Gould et al., *Predictors of Abortion Counseling Receipt and Helpfulness in the United States*, Women's Health Issues, 23(4): 249-255 (2013) <https://www.whijournal.com/article/S1049-3867(13)00039-X/fulltext> (accessed Feb. 5, 2024); Foster et al., *Attitudes and Decision Making Among Women Seeking Abortions at One US Clinic*, Perspectives on Sexual and Reproductive Health, 44(2): 117-124 (2012), <https://www.guttmacher.org/sites/default/files/article_files/4411712.pdf> (accessed Feb. 4, 2024); *see also* Kumar, U., et al., *Decision Making and Referral Prior to Abortion: A Qualitative Study of Women's Experiences*, Journal of Family Planning and Reproductive Health Care, 30(1): 51-54 (2004),<https://srh.bmj.com/content/familyplanning/30/1/51.full.pdf> (accessed Feb. 4, 2024).

[45] Nat'l Acads. of Sci., Eng'g, & Med., *supra* note 1, at 149-152; Academy of Medical Royal Colleges, *Induced Abortion and Mental Health* 1-248 (2011) <https://www.aomrc.org.uk/wp-

69. Abortion providers are trained to provide individualized informed consent counseling. MSFC's programs, for example, provide such training and teach about how to counsel patients holistically, including by assessing their certainty and encouraging them to take as much time as they need.

70. Northland reports that they have never seen the 24-Hour Delay benefit a single patient. The vast majority of Northland's patients are certain of their decision well before they walk through Northland's doors. And Northland's holistic counseling and informed consent process ensures that patients are informed about their care and that Northland addresses their needs in an individualized manner. For patients who are uncertain, they can take all the time they need to come to a decision. Like any quality healthcare provider, Northland does not provide services to people who are undecided about receiving care.

71. While abortion is extremely safe, delay incrementally increases the risks and complexity of abortion. Forcing pregnant people to delay abortion care is thus detrimental to their health and exposes them to greater risks with no medical justification.[46] For this reason, the

content/uploads/2016/05/Induced_Abortion_Mental_Health_1211.pdf> (accessed Feb. 4, 2024); Major et al., *Abortion and mental health: Evaluating the evidence*, American Psychologist, 64(9):863-890 (2008) <https://www.apa.org/pubs/journals/features/amp-64-9-863.pdf> (accessed Feb. 4, 2024); Charles et al., *Abortion and long-term mental health outcomes: a systematic review of the evidence*, Contraception 78(6): 436-50 (2008) <https://pubmed.ncbi.nlm.nih.gov/19014789/> (accessed Feb. 5, 2024); Adler et al., *Psychological factors in abortion: A review*, American Psychologist, 47(10): 1194-1204 (1992) <https://pubmed.ncbi.nlm.nih.gov/1443858/> (accessed Feb. 5, 2024).

[46] Nat'l Acads. of Sci., Eng'g, & Med., *supra* note 1, at 77-78; Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, Obstetrics and Gynecology, 103(4): 729-737 (2004) <https://pubmed.ncbi.nlm.nih.gov/15051566/> (accessed Feb. 5, 2024).

National Academies recommends that abortion be performed "as early in pregnancy as possible," and considers timeliness one of the core dimensions of high quality care.[47]

72. In addition, studies have found that mandatory delay laws exacerbate the burdens that people experience in seeking abortion care, including by increasing costs, prolonging wait times, increasing the risk that a woman will have to reveal her decision to others, and potentially preventing a woman from having the type of abortion that she prefers or any abortion at all.[48] Mandatory waiting periods can place additional emotional burdens on women, causing them increased anxiety and discomfort.[49]

73. For example, a 2009 literature review of studies evaluating the impact of mandatory counseling and waiting period laws concluded that such laws are likely to increase both the personal and financial costs of obtaining an abortion, which may prevent some women from accessing abortion services altogether.[50] The review also found that such laws may delay women who are seeking abortions and result in a higher proportion of second-trimester abortions.[51]

74. Delay can mean that some pregnant people become ineligible for the abortion method most appropriate for them, and instead must undergo a more invasive, more expensive,

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[47] Nat'l Acads. of Sci., Eng'g, & Med., *supra* note 1, at 163.

[48] Roberts et al. (2016), *supra* note 44, at 184-186; White et al., *Experiences Accessing Abortion Care in Alabama Among Women Traveling for Services*, 26 Womens Health Issues 298–304 (2016), <https://pubmed.ncbi.nlm.nih.gov/26897655/>; Joyce et al., *The Impact of State Mandatory Counseling and Waiting Period Laws on Abortion: A Literature Review* 11, 15, Guttmacher Inst. (2009), <https://www.guttmacher.org/sites/default/files/pdfs/pubs/MandatoryCounseling.pdf> (accessed Feb. 4, 2024).

[49] Roberts et al., *supra* note 44, at 184-185.

[50] Joyce et al., *supra* note 48, at 7–10.

[51] *Id.* at 9.

and/or lengthier abortion procedure. Medication abortion, which is preferred by many, and is the most common method of abortion in the United States, is available at Northland only up to 11 weeks, and even a short delay can push patients outside this window. Delay can also mean that people become ineligible for a first trimester abortion (available up to 13 weeks, 6 days LMP), and are forced to incur substantially higher costs to obtain a second trimester abortion. Later in pregnancy, procedural abortion becomes more complex—as pregnancy advances beyond approximately 14 weeks, it can become a two-day procedure to accomplish advanced dilation of the cervix.

75. The 24-Hour Delay's impacts are particularly severe for those who already face systemic barriers to accessing care, including Black women and other people of color, indigenous people, low-income people, and rural people, which makes the impact of the delay on these groups particularly severe. And it can be very difficult for people living on low incomes to take time off work and arrange childcare. People without means already face burdens in saving enough money to afford a first trimester procedure. For patients who struggle to afford a first trimester procedure, a second trimester procedure could be financially out of reach. Most patients who access abortion at Northland require some kind of financial assistance.

76. The printing requirement is particularly burdensome as most of Northland's patients don't have printers or computers at home—most use a smart phone as their sole device. Northland reports that at least 10 patients a month are waylaid by this requirement. They come in for care, but are told that they need to sign a physical copy of the acknowledgement and consent form and then are forced to wait another 24 hours.

77. Delays are all the more problematic in the post-*Roe* world, where people are traveling long distances to seek care in the states where abortion remains legal.

78. Further, the 24-Hour Delay impedes medical training for MSFC's members because the requirement is devoid of a scientific basis and inconsistent with the standard of care. When medical students or residents navigate a restriction to medical care that does not benefit patient outcomes and is not based in science, they are no longer learning medicine in an environment that is consistent with best educational practices.

79. Michigan does not impose any such mandatory delay on any other procedures, including medical procedures that pose far greater risks than abortion.

80. For all of these reasons, the 24-Hour Delay violates the fundamental constitutional right to abortion enshrined in the RFFA. And, because it discriminates against people who seek one form of reproductive healthcare and disproportionately impacts communities of color, low-income people, rural people, and others who face systemic barriers to healthcare access, it also violates RFFA's prohibition on discrimination. Further, the requirement harms Northland and MSFC individually by undermining the provision of evidence-based care and evidence-based medical training.

B. The Mandatory Biased Counseling

81. This one-size-fits-all requirement that providers dispense the State's version of relevant information does not provide any medical benefit and actually thwarts the true goals of informed consent, which is inherently individualized. State-mandated counseling also undermines autonomous decision-making. The Mandatory Biased Counseling forces providers to tell patients information that is unnecessary, irrelevant, inaccurate, and/or stigmatizing—all for the purpose of dissuading people from choosing to have an abortion. The requirement damages patient-provider trust and takes time and attention away from information targeted at the individual patient's needs. The requirement also undermines medical training, as MSFC members are forced to learn how to

counsel patients in a legal context that does not support learning the best evidence-based counseling and informed consent practices.

82. The statute requires that an abortion provider must—not less than 24 hours before performing an abortion—(1) confirm the patient is pregnant and determine the probable gestational age of the fetus; (2) orally describe to the patient the gestational age, information about what to do should any complications arise from the abortion, and information about how to obtain pregnancy prevention resources; and (3) provide the patient with physical copies of the following: a summary of the procedure, a medically accurate depiction of a fetus at the gestational age nearest the probable gestational age of the patient's fetus, a prenatal care and parenting information packet, and a prescreening summary on prevention of coercion to abort. MCL 333.17015(3).

83. In addition, after a patient arrives for their appointment, before obtaining the patient's signature on the acknowledgement and consent form, "a physician personally . . . shall" (1) confirm that the patient has received a screening on coercion to abort; (2) inform the patient of the right to withhold or withdraw consent at any time before performance of the abortion; and (3) orally describe risks of any complications associated with abortion as well as risks of any complications that could arise should the patient choose to continue the pregnancy. *Id.* 333.17015(6).

84. The Mandatory Biased Counseling is at odds with the standard of care, which requires an unbiased, individualized informed consent process. The standard of care before providing any abortion is to provide patients with information that is necessary and relevant to their decision-making, including risks, benefits, and alternatives, afford the opportunity to ask questions, and ensure that the patient is certain of their decision. Abortion providers like Northland

are guided by ethical principles and professional standards in informing their patients with accurate, adequate, and understandable information that is individualized and medically relevant.

85. According to ACOG, "[t]he highest ethical standard for adequacy of clinical information requires that the amount and complexity of information be tailored to the desires of the individual patient and to the patient's ability to understand this information."[52] As a result, ACOG opposes laws that "interfere with the ability of physicians to have open, honest, and confidential communications with their patients."[53] Laws that "interfere with the patient's right to be counseled by a physician according to the best currently available medical evidence and the physician's professional medical judgment" are contrary to informed consent.[54] Indeed, "[e]xamples of legislative interference in the informed consent process include state-mandated consent forms" and "laws that require physicians to give, or withhold, specific information when counseling patients before undergoing an abortion."[55]

86. Informed consent is grounded in respect for patient autonomy—its purpose is to ensure that patients have control over their own bodies and can make their own healthcare decisions. A respectful informed consent process is critical to establishing trust between patients and providers. Non-medical, inaccurate, irrelevant, or biased information undermines these principles. Conveying the state's disapproval of a patient's healthcare choices is the antithesis of

[52] American College of Obstetricians & Gynecologists, ACOG Committee Op. No. 819 (Feb. 2021), <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2021/02/informed-consent-and-shared-decision-making-in-obstetrics-and-gynecology.pdf> (accessed Feb. 4, 2024).

[53] *Id.*

[54] *Id.*

[55] *Id.*

informed consent, as is forcing patients to consume uniform information not tailored to their individual circumstances.

87. Northland reports that they have never seen the Mandatory Biased Counseling benefit a single patient. Rather, the requirement is a needless overlay that takes time away from the actual, holistic counseling Northland does with each patient. When MSFC provides and facilitates training for its members, it needs to ensure that they are learning how to counsel patients via the best evidence-based methods. Forcing providers to dispense and patients to consume unnecessary, misleading, inaccurate, and/or stigmatizing information is not consistent with evidence-based medicine.

88. The Mandatory Biased Counseling contains extensive fetal imagery and is heavily weighted toward encouraging continuing a pregnancy. These materials are designed to induce shame and persuade people to change their mind about having an abortion regardless of their personal circumstances. According to providers, the fetus in the image included in the mandatory materials is often more developed than an actual fetus, making this information inaccurate, misleading, and even disturbing.

89. MCL 333.17015 also requires the Michigan Department of Health and Human Services to create materials that inform patients of risks of "depression" and "feelings of guilt" and "[i]dentify services available through public agencies" should a patient "experience subsequent adverse psychological effects from" an abortion. *Id.* 333.17015(11)(b)(iii), (vii). But people are *not* more likely to experience depression after having an abortion.[56] They are, however,

[56] Nat'l Acads. of Sci., Eng'g, & Med., *supra* note 1, at 151; Academy of Medical Royal Colleges, *supra* note 45, at 98-99, 123-125; Major et al., *supra* note 45; Charles et al., *Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence*, Contraception 78(6):436-50 (2008) <https://pubmed.ncbi.nlm.nih.gov/19014789/> (accessed Feb. 5, 2024); Adler et al.

more likely to experience lower self-esteem, lower life satisfaction, and more anxiety symptoms if they cannot access a wanted abortion.[57]

90. Further, most people who have abortions are already parents. It is particularly inappropriate to inundate these patients with materials on prenatal care and parenting. The information is cruel to those with much wanted pregnancies who choose to have an abortion because of a severe diagnosis.

91. Patients must also be "screened" for coercion via a uniform set of requirements under the challenged statute. MCL 333.17015a. But providers already ensure that patients are not facing coercion. Further, for patients experiencing intimate partner violence who choose abortion to avoid being further tethered to their abuser, this screening can be upsetting and a grave interruption in the trust they have with their provider.

Psychological Factors in Abortion: A Review, American Psychologist, 47(10): 1194-1204 (1992) <https://pubmed.ncbi.nlm.nih.gov/1443858/> (accessed Feb. 5, 2024).

[57] Biggs et al., *Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Study,* JAMA Psychology, 74(2): 169-178 (2017), <https://docs.house.gov/meetings/IF/IF14/20200212/110504/HHRG-116-IF14-20200212-SD046.pdf> (accessed Feb. 4, 2024); *See also* Biggs et al., *Does Abortion Increase Women's Risk for Post-Traumatic Stress?: Findings From a Prospective Longitudinal Cohort Study*, BMJ Open, 6(2): e009698 (2016) <https://bmjopen.bmj.com/content/bmjopen/6/2/e009698.full.pdf> (accessed Feb. 4, 2024); Biggs et al., *Mental Health Diagnoses 3 Years After Receiving or Being Denied an Abortion in the United States*, American Journal of Public Health, 105(12): 2557-2563 (2016) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4638270/pdf/AJPH.2015.302803.pdf> (accessed Feb. 4, 2024); 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*, BMC Women's Health, 14: 76 (2014) <https://bmcwomenshealth.biomedcentral.com/counter/pdf/10.1186/1472-6874-14-76.pdf> (accessed Feb. 4, 2024); Jovel et al., *Abortion Waiting Periods and Decision Certainty Among People Searching Online for Abortion Care*, Obstetrics and Gynecology, 137(4): 597-605 (2021), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7984762/pdf/ong-137-597.pdf> (accessed Feb. 4, 2024).

92. No other form of healthcare in Michigan is subject to an overlay of uniform materials and information, much less information that is biased and designed to discourage people from accessing care. Healthcare providers in every other area of medicine in Michigan obtain informed consent through an individualized process in line with the standard of care for their specialties and their ethical obligations.

93. Further, Black women and other people of color, indigenous people, low-income people, and rural people, among others who face systemic barriers to healthcare access are disproportionately impacted by stigma and coercion based on the history of discrimination they have faced, including within the healthcare system. The Mandatory Biased Counseling undermines the patient-provider relationship, which reinforces the ways these communities have already had their reproductive choices manipulated.

94. For all of these reasons, the Mandatory Biased Counseling violates the fundamental constitutional right to abortion enshrined in the RFFA. And because it discriminates against people who seek one form of reproductive healthcare and disproportionately impacts communities of color, low-income people, rural people, and others who face systemic barriers to healthcare access, it also violates the RFFA's prohibition on discrimination. Further, the requirement harms Northland and MSFC individually by undermining the provision of evidence-based care and evidence-based medical training.

C. The Provider Ban

95. The Challenged Laws also include a "physician only" provision that thereby bans health care providers who are not physicians from providing abortions, *i.e.*, the Provider Ban. MCL 333.17015 (a "*physician* shall not perform an abortion . . . without the patient's informed written consent . . .") (emphasis added).

96. But for the Provider Ban, Northland and other providers in Michigan could hire Advanced Practice Clinicians ("APCs") like Certified Nurse Midwives ("CNMs"), Nurse Practitioners ("NPs"), and Physician Assistants/Associates ("PAs") to provide early abortions and thus greatly expand available services and appointments. Hiring APCs to provide abortions would also free up physician time for more complex care. The increased availability of procedural care is particularly important in the post-*Roe* world because so many patients are traveling long distances.

97. APCs are highly qualified clinicians who, based on advanced education and training, have a broad scope of practice, including extensive prescriptive authority and the ability to perform a range of complex medical procedures. APCs routinely provide abortions in other states, including in California, Colorado, Illinois, Maine, Montana, New Hampshire, New York, Oregon, Vermont, Virginia, Washington, Connecticut, Hawaii, Maryland, New Jersey, Rhode Island, and the District of Columbia.

98. Research shows no difference in outcomes between an early abortion provided by an APC and one provided by a physician.[58] Complication rates and other safety measures are the same.[59]

99. For these reasons, every mainstream professional organization to weigh in on APCs providing abortions has affirmed that these clinicians should not be prohibited from providing

[58] Am. Coll. of Obstetricians & Gynecologists (Dec. 2020), ACOG Committee Op. No. 815 (replacing Committee Opinion No. 613) (Nov. 2014), <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2020/12/increasing-access-to-abortion.pdf> (accessed Feb. 4 2024).

[59] *See* Goldman et al., *Physician Assistants as Providers of Surgically Induced Abortion Services,* 94 Am. J. Pub. Health 1352, 1355-56 (2004), <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.94.8.1352?download=true> (accessed Feb. 4, 2024).

abortion care. ACOG published an opinion in December 2020 calling for the repeal of requirements that only physicians or obstetrician-gynecologists provide abortion care and stating that the literature supports that "trained advanced practice clinicians can safely provide abortion services."[60] The American Public Health Association issued a Policy Statement in 2011 stating, "[t]here is evidence that with appropriate education and training, NPs, CNMs, and PAs can competently provide all components of medication abortion care (pregnancy testing counseling, estimating gestational age by exam and ultrasound, medical screening, administering medications, and postabortion follow-up care)[.]"[61] It recommended that APCs be engaged in the provision of early abortions and that scope-of-practice regulations should align with this recommendation.[62] The World Health Organization similarly recommends that medication abortion be managed by "traditional and complementary medicine professionals, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners" as well as community health workers, pharmacy workers, and patients themselves.[63] The National Academies concluded based on extensive research that a wide array of clinicians, including APCs, provide safe and effective medication and aspiration abortions consistent with training and experience. And it concluded that policies "establishing higher-level credentials than are

[60] ACOG Committee Op. 815, *supra* note 58.

[61] Am. Pub. Health Ass'n, Policy Number 20112, Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants (2011), <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/28/16/00/provision-of-abortion-care-by-advanced-practice-nurses-and-physician-assistants> (accessed Feb. 4, 2024).

[62] *Id.*

[63] World Health Organization, Abortion Care Guideline, at xxxii (2022), <https://apps.who.int/iris/rest/bitstreams/1394380/retrieve> (accessed Feb. 4, 2024).

necessary" thereby "reduce the availability of providers" and result in "inequitable access" to care, "limit patient preferences," "impact[] patient-centered care," and reduce "efficiency of care."[64]

100. There is no logical reason—let alone any reason related to patient health—to prevent APCs in Michigan from providing early abortion care consistent with their training and experience. In Michigan, APCs manage early miscarriages with *the very same techniques* they could use for patients seeking abortion. APCs' prescriptive authority includes risky controlled substances. Some APCs also provide far more complex care than abortion—CNMs provide obstetrical care, for example, and childbirth is far more dangerous than any method of abortion.[65]

101. While failing to advance patient health in any way, the Provider Ban contributes to logistical barriers by reducing the availability of abortion care. As mentioned above, as of 2022, 87% of Michigan counties had no abortion clinic. Over one-third of Michigan women and people of reproductive age live in these counties.[66] This deficiency is particularly dire in the predominantly rural Upper Peninsula and northeastern Lower Peninsula.[67] Because APCs are more likely to provide medical care in rural areas and other medical deserts, allowing them to provide abortions to the extent of their training and competence would likely give Michiganders more locations to obtain abortion care. Preventing qualified providers from entering the field (because the law disfavors abortion) disproportionately affects those who already struggle to access care,

[64] Nat'l Acads of Sci., Eng'g, & Med., *supra* note 1, at 118.

[65] Raymond et al., *supra* note 6, at 216.

[66] *Michigan, State Facts About Abortion*, Guttmacher Institute (2022), *see supra* note 19.

[67] *See* Donahue, *Abortion Access in Northern Michigan Is Already Limited. Restrictive Laws Make It Worse*, Mich. Advance (Jan. 30, 2022), <https://michiganadvance.com/2022/01/30/abortion-access-in-northern-michigan-is-already-limited-restrictive-laws-make-it-worse/> (accessed Feb. 4, 2024).

including Black women and other people of color, indigenous people, low-income people, and rural people. This further exacerbates the effects of poor maternity care generally. As of 2015, Michigan's 57 rural counties only had 29 hospitals providing maternity care.[68]

102. For all of these reasons, the Provider Ban violates the fundamental constitutional right to abortion enshrined in the RFFA. And because it discriminates against one form of reproductive healthcare—including by barring APCs from providing identical care to abortion patients that they already provide to miscarriage patients—the Provider Ban also violates the RFFA's prohibition on discrimination. It also discriminates because it disproportionately impacts communities of color, low-income people, rural people, and others who face systemic barriers to healthcare access. Further, the requirement harms Northland and MSFC individually by undermining the provision of evidence-based care and evidence-based medical training.

VI. CLAIMS FOR RELIEF

FIRST CLAIM FOR RELIEF
Const 1963, Art I, § 28(1) RFFA – Fundamental Constitutional Right to Abortion

103. Plaintiffs hereby re-allege and incorporate by reference paragraphs 1 through 102 above.

104. The Challenged Laws each violate Section (1) of the RFFA by denying, burdening, and infringing Michiganders' fundamental right to reproductive freedom, which encompasses the right to abortion, without medical justification, and do so by imposing requirements that are inconsistent with the standard of care and that intrude on patients' autonomous decision-making. Further, the Challenged Laws harm Northland and MSFC individually by undermining the provision of evidence-based care and evidence-based medical training.

[68] Wendling, *supra* note 20, at 567, 569.

SECOND CLAIM FOR RELIEF
Const 1963, Art I, § 28(2) RFFA – Nondiscrimination

110. Plaintiffs hereby re-allege and incorporate by reference paragraphs 1 through 102 above.

111. The Challenged Laws violate Section (2) of RFFA by discriminating in the protection and enforcement of the right to reproductive freedom in at least two ways. First, each of the Challenged Laws singles out abortion providers and people seeking abortion from their counterparts in other areas of reproductive healthcare like obstetrical care. Second, each of the Challenged Laws visits particular harms on certain Michigan communities, including Black people and other people of color, indigenous people, low-income people, and rural people.

VII. REQUEST FOR RELIEF

WHEREFORE Plaintiffs request that the Court:

A. Issue a Declaratory Judgment that the Challenged Laws are unconstitutional because they violate the RFFA;

B. Enjoin Defendants, their successors, agents, servants, employees, and attorneys, and all persons in active concert or participation with them, including all persons supervised by the Defendants, from enforcing the Challenged Laws preliminarily without bond and permanently;

C. Grant such other and further relief as this Court deems just, proper, and equitable, including an award of costs and attorney's fees to Plaintiffs.

Respectfully submitted, this 6th day of February,

/s/David A. Moran

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**Pro Hac Vice* Applications Forthcoming

COUNSEL FOR PLAINTIFFS

VERIFICATION

STATE OF MI)
)ss
COUNTY OF Oakland)

I declare that the above statements set forth in this Verified Complaint are true to the best of my knowledge, information, and belief.

Renee Chelian, Executive Director on behalf of Northland Family Planning Center, Northland Family Planning Center Inc. East, and Northland Family Planning Center Inc. West

Subscribed and sworn before me this 6th day of February 2024.

Signed:
Printed name: Anthony Mansoor

My Commission Expires: 07/07/2030

ANTHONY PAUL MANSOOR
Notary Public - State of Michigan
County of Oakland
My Commission Expires Jul 7, 2030
Acting in the County of Oakland

VERIFICATION

STATE OF Illinois)
)ss
COUNTY OF Madison)

I declare that the above statements set forth in this Verified Complaint are true to the best of my knowledge, information, and belief.

Pamela Merritt, Executive Director
on behalf of Medical Students for
Choice

Subscribed and sworn before me this
5 day of February 2024.

Signed: _____
Printed name: Lynne M Skosky

My Commission Expires: 6/5/25

"OFFICIAL SEAL"
LYNNE M. SKOSKY
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 06/05/25

EXHIBIT A

PUBLIC HEALTH CODE (EXCERPT)
Act 368 of 1978

***** *333.17015.amended THIS AMENDED SECTION IS EFFECTIVE FEBRUARY 13, 2024* *****

333.17015.amended Informed consent; definitions; duties of physician or assistant; location; disclosure of information; view of ultrasound; medical emergency necessitating abortion; duties of department; physician's duty to inform patient; validity of consent or certification form; right to abortion not created; prohibition; portion of act found invalid; duties of local health department; confidentiality.

Sec. 17015. (1) Subject to subsection (10), a physician shall not perform an abortion otherwise permitted by law without the patient's informed written consent, given freely and without coercion to abort.

(2) For purposes of this section and section 17015a:

(a) "Abortion" means the intentional use of an instrument, drug, or other substance or device to terminate a woman's pregnancy for a purpose other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a fetus that has died as a result of natural causes, accidental trauma, or a criminal assault on the pregnant woman. Abortion does not include the use or prescription of a drug or device intended as a contraceptive.

(b) "Coercion to abort" means an act committed with the intent to coerce an individual to have an abortion, which act is prohibited by section 213a of the Michigan penal code, 1931 PA 328, MCL 750.213a.

(c) "Domestic violence" means that term as defined in section 1 of 1978 PA 389, MCL 400.1501.

(d) "Fetus" means an individual organism of the species Homo sapiens in utero.

(e) "Local health department representative" means an individual who meets 1 or more of the licensing requirements listed in subdivision (h) and who is employed by, or under contract to provide services on behalf of, a local health department.

(f) "Medical emergency" means a condition which, on the basis of the physician's good-faith clinical judgment, so complicates the medical condition of a pregnant individual as to necessitate the immediate abortion of the individual's pregnancy to avert the individual's death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

(g) "Medical service" means the provision of a treatment, procedure, medication, examination, diagnostic test, assessment, or counseling, including, but not limited to, a pregnancy test, ultrasound, pelvic examination, or an abortion.

(h) "Qualified person assisting the physician" means another physician or a physician's assistant licensed under this part or part 175, a fully licensed or limited licensed psychologist licensed under part 182, a professional counselor licensed under part 181, a registered professional nurse or a licensed practical nurse licensed under part 172, or a social worker licensed under part 185.

(i) "Probable gestational age of the fetus" means the gestational age of the fetus at the time an abortion is planned to be performed.

(j) "Provide the patient with a physical copy" means confirming that the patient accessed the internet website described in subsection (5) and received a printed valid confirmation form from the website and including that form in the patient's medical record or giving a patient a copy of a required document by 1 or more of the following means:

(*i*) In person.

(*ii*) By registered mail, return receipt requested.

(*iii*) By parcel delivery service that requires the recipient to provide a signature in order to receive delivery of a parcel.

(*iv*) By facsimile transmission.

(3) Subject to subsection (10), a physician or a qualified person assisting the physician shall do all of the following not less than 24 hours before that physician performs an abortion upon a patient who is pregnant:

(a) Confirm that, according to the best medical judgment of a physician, the patient is pregnant, and determine the probable gestational age of the fetus.

(b) Orally describe, in language designed to be understood by the patient, taking into account the patient's age, level of maturity, and intellectual capability, each of the following:

(*i*) The probable gestational age of the fetus the patient is carrying.

(*ii*) Information about what to do and whom to contact should medical complications arise from the abortion.

(*iii*) Information about how to obtain pregnancy prevention information through the department of health and human services.

(c) Provide the patient with a physical copy of the written standardized summary described in subsection (11)(b) that corresponds to the procedure the patient will undergo and is provided by the department of health and human services. If the procedure has not been recognized by the department of health and human services, but is otherwise allowed under Michigan law, and the department of health and human services has not provided a written standardized summary for that procedure, the physician shall develop and provide a written summary that describes the procedure, any known risks or complications of the procedure, and risks associated with live birth and meets the requirements of subsection (11)(b)(*iii*) through (*vii*).

(d) Provide the patient with a physical copy of a medically accurate depiction, illustration, or photograph and description of a fetus supplied by the department of health and human services pursuant to subsection (11)(a) at the gestational age nearest the probable gestational age of the patient's fetus.

(e) Provide the patient with a physical copy of the prenatal care and parenting information pamphlet distributed by the department of health and human services under section 9161.

(f) Provide the patient with a physical copy of the prescreening summary on prevention of coercion to abort described in subsection (11)(i).

(4) The requirements of subsection (3) may be fulfilled by the physician or a qualified person assisting the physician at a location other than the health facility where the abortion is to be performed. The requirement of subsection (3)(a) that a patient's pregnancy be confirmed may be fulfilled by a local health department under subsection (18). The requirements of subsection (3) cannot be fulfilled by the patient accessing an internet website other than the internet website that is maintained and operated by the department of health and human services under subsection (11)(g).

(5) The requirements of subsection (3)(c) through (f) may be fulfilled by a patient accessing the internet website that is maintained and operated by the department of health and human services under subsection (11)(g) and receiving a printed, valid confirmation form from the website that the patient has reviewed the information required in subsection (3)(c) through (f) at least 24 hours before an abortion being performed on the patient. The website must not require any information be supplied by the patient. The department of health and human services shall not track, compile, or otherwise keep a record of information that would identify a patient who accesses this website. The patient shall supply the valid confirmation form to the physician or qualified person assisting the physician to be included in the patient's medical record to comply with this subsection.

(6) Subject to subsection (10), before obtaining the patient's signature on the acknowledgment and consent form, a physician personally and in the presence of the patient shall do all of the following:

(a) Provide the patient with the physician's name, confirm with the patient that the coercion to abort screening required under section 17015a was performed, and inform the patient of the right to withhold or withdraw consent to the abortion at any time before performance of the abortion.

(b) Orally describe, in language designed to be understood by the patient, taking into account the patient's age, level of maturity, and intellectual capability, each of the following:

(*i*) The specific risk, if any, to the patient of the complications that have been associated with the procedure the patient will undergo, based on the patient's particular medical condition and history as determined by the physician.

(*ii*) The specific risk of complications, if any, to the patient if the patient chooses to continue the pregnancy based on the patient's particular medical condition and history as determined by a physician.

(7) To protect a patient's privacy, the information set forth in subsection (3) and subsection (6) must not be disclosed to the patient in the presence of another patient.

(8) If at any time before the performance of an abortion, a patient undergoes an ultrasound examination, or a physician determines that ultrasound imaging will be used during the course of a patient's abortion, the physician or qualified person assisting the physician shall provide the patient with the opportunity to view or decline to view an active ultrasound image of the fetus, and offer to provide the patient with a physical picture of the ultrasound image of the fetus before the performance of the abortion. After the expiration of the 24-hour period prescribed under subsection (3) but before performing an abortion on a patient who is pregnant, a physician or a qualified person assisting the physician shall do all of the following:

(a) Obtain the patient's signature on the acknowledgment and consent form described in subsection (11)(c) confirming that the patient has received the information required under subsection (3).

(b) Provide the patient with a physical copy of the signed acknowledgment and consent form described in subsection (11)(c).

(c) Retain a copy of the signed acknowledgment and consent form described in subsection (11)(c) and, if applicable, a copy of the pregnancy certification form completed under subsection (18)(b), in the patient's medical record.

(9) This subsection does not prohibit notifying the patient that payment for medical services will be

required or that collection of payment in full for all medical services provided or planned may be demanded after the 24-hour period described in this subsection has expired. A physician or an agent of the physician shall not collect payment, in whole or in part, for a medical service provided to or planned for a patient before the expiration of 24 hours from the time the patient has done either or both of the following, except in the case of a physician or an agent of a physician receiving capitated payments or under a salary arrangement for providing those medical services:

(a) Inquired about obtaining an abortion after the patient's pregnancy is confirmed and the patient has received from that physician or a qualified person assisting the physician the information required under subsection (3)(c) and (d).

(b) Scheduled an abortion to be performed by that physician.

(10) If the attending physician, utilizing the physician's experience, judgment, and professional competence, determines that a medical emergency exists and necessitates performance of an abortion before the requirements of subsections (1), (3), and (6) can be met, the physician is exempt from the requirements of subsections (1), (3), and (6), may perform the abortion, and shall maintain a written record identifying with specificity the medical factors upon which the determination of the medical emergency is based.

(11) The department of health and human services shall do each of the following:

(a) Produce medically accurate depictions, illustrations, or photographs of the development of a human fetus that indicate by scale the actual size of the fetus at 2-week intervals from the fourth week through the twenty-eighth week of gestation. Each depiction, illustration, or photograph must be accompanied by a printed description, in nontechnical English, Arabic, and Spanish, of the probable anatomical and physiological characteristics of the fetus at that particular state of gestational development.

(b) Subject to subdivision (e), develop, draft, and print, in nontechnical English, Arabic, and Spanish, written standardized summaries, based upon the various medical procedures used to abort pregnancies, that do each of the following:

(*i*) Describe, individually and on separate documents, those medical procedures used to perform abortions in this state that are recognized by the department of health and human services.

(*ii*) Identify the physical complications that have been associated with each procedure described in subparagraph (*i*) and with live birth, as determined by the department. In identifying these complications, the department shall consider studies concerning complications that have been published in a peer review medical journal, with particular attention paid to the design of the study, and shall consult with the Centers for Disease Control and Prevention, the American Congress of Obstetricians and Gynecologists, the Michigan State Medical Society, or any other source that the department of health and human services determines appropriate for the purpose.

(*iii*) State that as the result of an abortion, some individuals may experience depression, feelings of guilt, sleep disturbance, loss of interest in work or sex, or anger, and that if these symptoms occur and are intense or persistent, professional help is recommended.

(*iv*) State that not all of the complications listed in subparagraph (*ii*) may pertain to that particular patient and refer the patient to the patient's physician for more personalized information.

(*v*) Identify services available through public agencies to assist the patient during the patient's pregnancy and after the birth of the child, should the patient choose to give birth and maintain custody of the child.

(*vi*) Identify services available through public agencies to assist the patient in placing the child in an adoptive or foster home, should the patient choose to give birth but not maintain custody of the child.

(*vii*) Identify services available through public agencies to assist the patient and provide counseling should the patient experience subsequent adverse psychological effects from the abortion.

(c) Develop, draft, and print, in nontechnical English, Arabic, and Spanish, an acknowledgment and consent form that includes only the following language above a signature line for the patient:

"I, _____ , voluntarily and willfully hereby authorize Dr. _____ ("the physician") and any assistant designated by the physician to perform upon me the following operation(s) or procedure(s):

_____

(Name of operation(s) or procedure(s))

_____

A. I understand that I am approximately _____ weeks pregnant. I consent to an abortion procedure to terminate my pregnancy. I understand that I have the right to withdraw my consent to the abortion procedure at any time before performance of that procedure.

B. I understand that it is illegal for anyone to coerce me into seeking an abortion.

C. I acknowledge that at least 24 hours before the scheduled abortion I have received a physical copy of each of the following:

1. A medically accurate depiction, illustration, or photograph of a fetus at the probable gestational age of the fetus I am carrying.

2. A written description of the medical procedure that will be used to perform the abortion.

3. A prenatal care and parenting information pamphlet.

D. If any of the documents listed in paragraph C were transmitted by facsimile, I certify that the documents were clear and legible.

E. I acknowledge that the physician who will perform the abortion has orally described all of the following to me:

1. The specific risk to me, if any, of the complications that have been associated with the procedure I am scheduled to undergo.

2. The specific risk to me, if any, of the complications if I choose to continue the pregnancy.

F. I acknowledge that I have received all of the following information:

1. Information about what to do and whom to contact in the event that complications arise from the abortion.

2. Information pertaining to available pregnancy related services.

G. I have been given an opportunity to ask questions about the operation(s) or procedure(s).

H. I certify that I have not been required to make any payments for an abortion or any medical service before the expiration of 24 hours after I received the written materials listed in paragraph C, or 24 hours after the time and date listed on the confirmation form if the information described in paragraph C was viewed from the state of Michigan internet website.".

(d) Make available to physicians through the board and the Michigan board of osteopathic medicine and surgery, and to any person upon request, the copies of medically accurate depictions, illustrations, or photographs described in subdivision (a), the written standardized summaries described in subdivision (b), the acknowledgment and consent form described in subdivision (c), the prenatal care and parenting information pamphlet described in section 9161, the pregnancy certification form described in subdivision (f), and the materials regarding coercion to abort described in subdivision (i).

(e) In developing the written standardized summaries for abortion procedures under subdivision (b), include in the summaries only medication that has been approved by the United States Food and Drug Administration for use in performing an abortion.

(f) Develop, draft, and print a certification form to be signed by a local health department representative at the time and place a patient has a pregnancy confirmed, as requested by the patient, verifying the date and time the pregnancy is confirmed.

(g) Develop, operate, and maintain an internet website that allows a patient considering an abortion to review the information required in subsection (3)(c) through (f). After the patient reviews the required information, the department of health and human services shall ensure that a confirmation form can be printed by the patient from the internet website that will verify the time and date the information was reviewed. A confirmation form printed under this subdivision becomes invalid 14 days after the date and time printed on the confirmation form.

(h) Include on the informed consent internet website operated under subdivision (g) a list of health care providers, facilities, and clinics that offer to perform ultrasounds free of charge. The list must be organized geographically and include the name, address, and telephone number of each health care provider, facility, and clinic.

(i) After considering the standards and recommendations of the Joint Commission on Accreditation of Healthcare Organizations, the Michigan Domestic and Sexual Violence Prevention and Treatment Board, the Michigan Coalition to End Domestic and Sexual Violence or successor organization, and the American Medical Association, do all of the following:

(*i*) Develop, draft, and print or make available in printable format, in nontechnical English, Arabic, and Spanish, a notice that is required to be posted in facilities and clinics under section 17015a. The notice must be at least 8-1/2 inches by 14 inches, be printed in at least 44-point type, and contain at a minimum all of the following:

(A) A statement that it is illegal under Michigan law to coerce an individual to have an abortion.

(B) A statement that help is available if an individual is being threatened or intimidated; is being physically, emotionally, or sexually harmed; or feels afraid for any reason.

(C) The telephone number of at least 1 domestic violence hotline and 1 sexual assault hotline.

(*ii*) Develop, draft, and print or make available in printable format, in nontechnical English, Arabic, and Spanish, a prescreening summary on prevention of coercion to abort that, at a minimum, contains the information required under subparagraph (*i*) and notifies the patient that an oral screening for coercion to abort will be conducted before giving written consent to obtain an abortion.

(*iii*) Develop, draft, and print screening and training tools and accompanying training materials to be utilized by a physician or qualified person assisting the physician while performing the coercion to abort screening required under section 17015a. The screening tools must instruct the physician or qualified person assisting the physician to orally communicate information to the patient regarding coercion to abort and to document the findings from the coercion to abort screening in the patient's medical record.

(*iv*) Develop, draft, and print protocols and accompanying training materials to be utilized by a physician or a qualified person assisting the physician if a patient discloses coercion to abort or that domestic violence is occurring, or both, during the coercion to abort screening. The protocols must instruct the physician or qualified person assisting the physician to do, at a minimum, all of the following:

(A) Follow the requirements of section 17015a as applicable.

(B) Assess the patient's current level of danger.

(C) Explore safety options with the patient.

(D) Provide referral information to the patient regarding law enforcement and domestic violence and sexual assault support organizations.

(E) Document any referrals in the patient's medical record.

(12) A physician's duty to inform the patient under this section does not require disclosure of information beyond what a reasonably well-qualified physician licensed under this article would possess.

(13) A written consent form meeting the requirements set forth in this section and signed by the patient is presumed valid. The presumption created by this subsection may be rebutted by evidence that establishes, by a preponderance of the evidence, that consent was obtained through fraud, negligence, deception, misrepresentation, coercion, or duress.

(14) A completed certification form described in subsection (11)(f) that is signed by a local health department representative is presumed valid. The presumption created by this subsection may be rebutted by evidence that establishes, by a preponderance of the evidence, that the physician who relied upon the certification had actual knowledge that the certificate contained a false or misleading statement or signature.

(15) This section does not create a right to abortion.

(16) Notwithstanding any other provision of this section, a person shall not perform an abortion that is prohibited by law.

(17) If any portion of this act or the application of this act to any person or circumstances is found invalid by a court, that invalidity does not affect the remaining portions or applications of the act that can be given effect without the invalid portion or application, if those remaining portions are not determined by the court to be inoperable.

(18) Upon a patient's request, a local health department shall comply with the following:

(a) Provide a pregnancy test for that patient to confirm the pregnancy as required under subsection (3)(a) and determine the probable gestational stage of the fetus. The local health department need not comply with this subdivision if the requirements of subsection (3)(a) have already been met.

(b) If a pregnancy is confirmed, ensure that the patient is provided with a completed pregnancy certification form described in subsection (11)(f) at the time the information is provided.

(19) The identity and address of a patient who is provided information or who consents to an abortion pursuant to this section is confidential and is subject to disclosure only with the consent of the patient or by judicial process.

(20) A local health department with a file containing the identity and address of a patient described in subsection (19) who has been assisted by the local health department under this section shall do both of the following:

(a) Only release the identity and address of the patient to a physician or qualified person assisting the physician in order to verify the receipt of the information required under this section.

(b) Destroy the information containing the identity and address of the patient within 30 days after assisting the patient under this section.

History: Add. 1993, Act 133, Eff. Apr. 1, 1994;—Am. 2000, Act 345, Eff. Mar. 28, 2001;—Am. 2002, Act 685, Eff. Mar. 31, 2003;—Am. 2006, Act 77, Imd. Eff. Mar. 24, 2006;—Am. 2012, Act 499, Eff. Mar. 31, 2013;—Am. 2023, Act 209, Eff. Feb. 13, 2024.

Popular name: Act 368

Popular name: Informed Consent

EXHIBIT B

PUBLIC HEALTH CODE (EXCERPT)
Act 368 of 1978

333.17015a Coercion; screening; protocols; report; availability of publications about violence against women; right to abortion not created.

Sec. 17015a. (1) At the time a patient first presents at a private office, freestanding surgical outpatient facility, or other facility or clinic in which abortions are performed for the purpose of obtaining an abortion, whether before or after the expiration of the 24-hour period described in section 17015(3), the physician or qualified person assisting the physician shall orally screen the patient for coercion to abort using the screening tools developed by the department under section 17015(11). The oral screening required under this subsection may occur before the requirements of section 17015(3) have been met with regard to that patient.

(2) If a patient discloses that she is the victim of domestic violence that does not include coercion to abort, the physician or qualified person assisting the physician shall follow the protocols developed by the department under section 17015(11).

(3) If a patient discloses coercion to abort, the physician or qualified person assisting the physician shall follow the protocols developed by the department under section 17015(11).

(4) If a patient who is under the age of 18 discloses domestic violence or coercion to abort by an individual responsible for the health or welfare of the minor patient, the physician or qualified person assisting the physician shall report that fact to a local child protective services office.

(5) A private office, freestanding surgical outpatient facility, or other facility or clinic in which abortions are performed shall post in a conspicuous place in an area of its facility that is accessible to patients, employees, and visitors the notice described in section 17015(11)(i). A private office, freestanding surgical outpatient facility, or other facility or clinic in which abortions are performed shall make available in an area of its facility that is accessible to patients, employees, and visitors publications that contain information about violence against women.

(6) This section does not create a right to abortion. Notwithstanding any other provision of this section, a person shall not perform an abortion that is prohibited by law.

History: Add. 2012, Act 499, Eff. Mar. 31, 2013.

Popular name: Act 368