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SUPERIOR COURT OF ARIZONA
MARICOPA COUNTY

CV 2025-017995 02/02/2026

HONORABLE GREG S. COMO

CLERK OF THE COURT
C. Lacey
Deputy

PAUL A ISAACSON, et al.

KRISTINE J BEAUDOIN
JUSTIN SMITH

v.

STATE OF ARIZONA

LUCI D DAVIS

THOMAS J. BASILE
LAUREN KARA BEALL
REBECCA CHAN
JOHANNA ZACARIAS
CAROLINE SACERDOTE
LAURA BAKST
OLIVIA ROAT
ANDREW W GOULD
EMILY GOULD
ERICA LEAVITT
JARED G KEENAN
HAYLEIGH S CRAWFORD
ALEXANDER WESTBROOK SAMUELS
DOCKET CV TX
JUDGE COMO

MINUTE ENTRY

Ruling in Isaacson CV2025-017995

On November 5-7, the Court held an evidentiary hearing on Plaintiffs' claims for declaratory and injunctive relief. The Court heard final closing arguments on January 12, 2026, and took the matter under advisement. The Court now issues its ruling on all pending issues.

Introduction

Plaintiffs are two licensed OB-GYN doctors and the Arizona Medical Association. They bring this action seeking a judgment declaring that various statutes involving a woman's access to an abortion violate Arizona's Constitution. Plaintiffs characterize these statutes as: the Reason Ban Scheme; the Two-Trip Scheme; and the Telemedicine Ban Scheme (collectively "the Challenged Laws"). Plaintiffs seek to enjoin enforcement of these laws as applied to pre-viability abortions. The State, through the Attorney General, is largely aligned with Plaintiffs' position. The President of the Arizona Senate (Warren Petersen) and the Speaker of the Arizona House of Representatives (Steve Montenegro) have intervened to defend the Challenged Laws.

Standing/Ripeness

Intervenors argue that Plaintiffs lack standing because they face no real threat of being prosecuted, nor of facing professional discipline, for violating the Challenged Laws. The Court rejected this argument when it denied Intervenors' motion to dismiss. Order entered 9-23-25. The Court incorporates its previous ruling regarding standing/ripeness.

The evidence presented during the evidentiary hearing underscores the Court's previous decision. Doctors Isaacson and Richardson testified that the Challenged Laws force them to, among other things, delay abortion care, turn away patients, perform tests and medical procedures that are not medically necessary, and provide information to patients regardless of its relevance and irrespective of whether they wish to receive the information. FOF, *infra* ¶¶ 5, 7-8, 13, 16, 23-29 and 32-39. Thus, the testimony establishes that the Challenged Laws have direct, immediate and adverse impacts on the Plaintiff Doctors and their patients.

Further, while the threat of prosecution may be a *basis* for standing, it is not a *requirement* for standing. See *Brush & Nib Studio LC v. City of Phoenix*, 247 Ariz. 269, 280, ¶¶ 36-39 (2019). In *Brush & Nib*, custom wedding invitation designers challenged a City ordinance which prohibits businesses from refusing to provide goods or services to a person because of their status in a protected group. Id. at ¶ 18. The Court held that the plaintiffs had standing to pursue both declaratory and injunctive relief even though they had not been cited plaintiffs for

violating the ordinance and the plaintiffs had not refused to create invitations for same-sex customers. *Id*. at ¶¶ 22-23. Despite the lack of prosecution -- or even an alleged violation of the ordinance – the Court found that the plaintiffs' claims were not speculative because the parties had "analyzed, in detail, the legal claims and arguments based on these custom invitations." *Id.* at ¶ 37.

Also on point is *Planned Parenthood Center of Tucson, Inc., v. Marks,* 17 Ariz. App. 308 (App. 1972) (cited with approval in *Brush & Nib, supra*). In *Planned Parenthood,* the plaintiff sought to have certain statues declared unconstitutional because they criminalized providing an abortion to a woman and publishing the availability of abortion services. The State argued there was no justiciable controversy because the plaintiffs were not being prosecuted, nor threatened with prosecution, for violating the statutes. *Id.* at 310. The Court rejected this argument:

> To require statutory violation and exposure to grave legal sanctions; to force parties down the prosecution path, in effect compelling them to pull the trigger to discover if the gun is loaded divests them of the forewarning which the law, through the Uniform Declaratory Judgments Act, has promised. . . Violation of a criminal statute as a prerequisite to testing its validity invites disorder and chaos and subverts the very ends of law.

Planned Parenthood Center, 17 Ariz. App. at 312-13.

The parties' extensive litigation of the Challenged Laws proves there is an actual controversy that is ripe for decision. The Court held a three-day evidentiary hearing, during which it heard testimony from the Plaintiff Doctors, seven expert witnesses, and a rebuttal fact witness called by Intervenors. The parties admitted into evidence more than 45 exhibits and the witnesses referenced scores of scholarly articles on the health and safety of abortion care. The parties filed post-hearing briefs, with detailed proposed findings of fact and conclusions of law. As in *Brush & Nib*, the parties have "analyzed, in detail, the legal claims and arguments" regarding the constitutionality of the Challenged Laws. Plaintiffs, therefore, have standing.

Arizona's Standard for Regulation of Abortion

The Previous Standard: Undue Burden Test

Before *Dobbs v. Jackson Women's Health Organization,*[1] the State's power to regulate pre-viability abortion was governed by the "undue burden" test set forth in *Planned Parenthood*

[1] 142 S. Ct. 2228 (2022)

of Southeastern Pennsylvania v. Casey.[2] The *Casey* standard recognized the State's legitimate interest in both protecting the woman's health, and in the life of the fetus that may become a child. *Casey,* 112 S.Ct. at 2804.

*Casey's "*undue burden" standard looked at whether the purpose or effect of a law "is to place a substantial obstacle in the path of a woman seeking an abortion" before viability. *Id.* at 2821. Because of the State's "profound interest in potential life", *Casey* holds that the State may take measures to ensure that the woman's choice is informed, and such measures will not be invalidated "as long as their purpose if to persuade the woman to choose childbirth over abortion." *Id.* Further, the State may enact laws to further the health or safety of a woman seeking an abortion, however, unnecessary regulations that present a substantial obstacle to a woman seeking an abortion are invalid. *Id.*

Dobbs overruled *Casey. Casey* matters here only because Intervenors argue that Arizona's Constitutional Amendment effectively returns Arizona to the *Casey* standard. This contention flatly contradicts the plain language of Arizona's Constitutional Amendment.

Arizona's Constitutional Amendment

In November 2024, Arizonans approved Proposition 139, which amended the Arizona Constitution to add article II, § 8.1. The Amendment provides that "[e]very individual has a fundamental right to abortion." Ariz. Const. art. II, § 8.1(A).

For pre-viability abortions, the Amendment prohibits the state from enacting, adopting, or enforcing a law that either:

> 1. Denies, restricts or interferes with that right before fetal viability unless justified by a compelling state interest that is achieved by the least restrictive means.
>
> ***
>
> 3. Penalizes any individual or entity for aiding or assisting a pregnant individual in exercising the individual's right to abortion as provided in this section.

Ariz. Const. art. II, § 8.1(A)(1) and (3).

[2] 112 S.Ct. 2791 (1992)

The state has a "compelling state interest" only when both of the following requirements are met:

a. First, a law must be "enacted or adopted for the limited purpose of improving or maintaining the health of an individual seeking abortion care, consistent with accepted clinical standards of practice and evidence-based medicine."
b. And second, a law must "not infringe on that individual's autonomous decision making."

Id. § 8.1(B)(1)(a)-(b).

The above language bears no resemblance to *Casey's* undue burden test. Gone is *Casey's* "substantial obstacle" standard. Under Arizona's Constitution, the challenged law need only "restrict or interfere" with a woman's right to an abortion to trigger strict scrutiny. And virtually every regulation of abortion "interferes" with a woman's right to seek an abortion.

Once interference is shown, the burden shifts to the state to show that the regulation advances a compelling state interest. Significantly, the "compelling state interest" focuses exclusively on the *health and autonomy of the woman seeking an abortion.* Unlike *Casey*, the state's interest in protecting potential life is not a legitimate justification for a law that interferes with a woman's right to seek a pre-viability abortion.

Thus, in determining whether the Challenged Laws are valid, this ruling applies the plain text of Arizona's Constitution, not the overruled and inapplicable *Casey* standard.

FINDINGS OF FACT

The Challenged Laws

The Reason Ban

1. The Reason Ban prohibits providing abortion care depending on the patient's reasons for seeking the abortion. A.R.S. §§ 13-3603.02, 36-2157, 2158(A)(2)(d), 2161(A)(25). Specifically, the Reason Ban makes it a felony for any person to "[p]erform an abortion knowing that the abortion is sought solely because of a genetic abnormality of the child" and to "solicit or accept monies to finance . . . an abortion because of a genetic abnormality of the child." A.R.S. § 13-3603.02(A)(2), (B)(2). In addition, it requires the provider to execute an affidavit prior to every abortion swearing that they have "no knowledge" that the pregnancy is being terminated "because of a genetic abnormality of the child." A.R.S. § 36-2157.

2. The Reason Ban further prohibits abortion care unless the provider first tells pregnant patients diagnosed with a nonlethal fetal condition that Arizona law "prohibits abortion . . . because of a genetic abnormality." A.R.S. § 36-2158(A)(2)(d). And it imposes an affirmative obligation on providers to report to the Arizona Department of Health Services ("ADHS") "[w]hether any genetic abnormality of the unborn child was detected at or before the time of the abortion." A.R.S. § 36-2161(A)(25).

3. The Reason Ban defines "genetic abnormality" as "the presence or presumed presence of an abnormal gene expression in an unborn child, including a chromosomal disorder or morphological malformation occurring as the result of abnormal gene expression." A.R.S. § 13-3603.02(G). It excludes a "lethal fetal condition," *id.*, which is defined as "a fetal condition that is diagnosed before birth and that will result, with reasonable certainty, in the death of the unborn child within three months after birth," A.R.S. § 36-2158(G)(1).

4. Beyond facing felony liability, those who violate any provision of the Reason Ban risk suspension or revocation of their medical license, public censure, and civil penalties of at least $1,000 and up to $10,000 for each violation found. A.R.S. §§ 32-1401(27), 32-1403(A)(2), (A)(5), 32-1403.01(A), 32-1451(A), (D)-(E), (I), and (K). The Reason Ban also imposes civil liability on any "physician, physician's assistant, nurse, counselor or other medical or mental health professional who knowingly does not report known violations … to appropriate law enforcement authorities." A.R.S. § 13-3603.02(E).

5. Dr. Isaacson has had to turn away patients due to the Reason Ban. Tr. 11/05/25 (Isaacson) at 30:7-9.

6. Before the Reason Ban went into effect, Arizona abortion doctors could – and some did - provide care to patients they knew were seeking abortion after a fetal diagnosis. Tr. 11/05/25 (Isaacson) at 28:24-29:2. During that time, doctors would refer patients who received a fetal diagnosis and, after counseling, chose to terminate their pregnancy, to abortion providers such as Dr. Isaacson. *Id.* at 29:3-7. Since the Reason Ban went into effect, such referrals have declined significantly. *Id.* at 29:8-10.

7. Patients considering an abortion because of a fetal diagnosis cannot share their reasoning with their abortion provider for fear of being turned away. Tr. 11/05/25 (Isaacson) at 30:24-31:5. This undermines providers' ability to communicate with their patients, Tr. 11/05/25 (Isaacson) at 31:6-9; deprives them of the ability to learn medically relevant information, Tr.

11/05/25 (Isaacson) at 30:14-23; Tr. 11/06/25 (Cunningham) at 68:15-70:24; and "destroys" the physician-patient relationship, Tr. 11/06/25 (Wenstrom) at 31:13-19.

8. Reason bans are a "gross interference in the physician-patient relationship, creating a system in which patients and physicians are forced to withhold information or outright lie in order to ensure access to care" and "forcing women to carry pregnancies to term[.]" ACOG, *Statement on Abortion Reason Bans* 1 (Mar. 2016) ("ACOG *Statement on Reason Bans*") (PX-45)[3].

9. The Reason Ban overrides patients' ability to make an autonomous decision to obtain a fetal autopsy after an abortion, which could provide helpful information about fetal diagnoses and implications for future pregnancies but cannot be done if the abortion provider is unaware of the fetal condition and desire for testing. Tr. 11/06/25 (Wenstrom) at 24:1-25:25.

10. The Reason Ban is inconsistent with patient autonomy because it inhibits informed decision making. Tr. 11/06/25 (Cunningham) at 69:2-3. The Ban prohibits patients from disclosing information to their abortion provider that is material to them if they want to receive the health care of their choice. *Id.* at 68:22-69:5.

11. A component of patient autonomy is providing patients with a sense of control, which is particularly important as people who receive a fetal diagnosis often feel out of control. Tr. 11/06/25 (Wenstrom) at 22:24-23:19, 34:10-21. Preventing patients from sharing their fetal diagnosis with their abortion provider deprives them of the opportunity to obtain care in a way that is sensitive to their need to "feel [that] they are in control." *Id.* at 34:10-21, 35:19-36:9.

12. The Reason Ban is not consistent with accepted clinical standards of practice or evidence-based medicine. Tr. 11/06/25 (Wenstrom) at 33:24-34:9; Tr. 11/06/25 (Cunningham) at 68:5-70:4. Restricting abortions based on a woman's reason for needing one is not medically appropriate and endangers the health of women. ACOG, *Statement on Reason Bans* at 1 (PX-45 at 1). As to restrictions based on genetic anomalies specifically, ACOG further advises that they "cause additional severe emotional pain for women and their families." *Id.*

13. The denial of wanted abortion care undermines, and does not improve or maintain, the health of the person seeking the abortion. ACOG, *Statement on Reason Bans* (PX-45). The Reason Ban prevents providers from learning the full scope of their patients' medical history, Tr. 11/05/25 (Isaacson) at 30:14-23; Tr. 11/06/25 (Cunningham) at 68:15-70:4, including by cutting off information from referring providers about the overall condition of patients' pregnancies—

[3] PX- ___ refers to Plaintiffs' Exhibit ___, admitted during the evidentiary hearing.

information that may have significant impact on how an abortion procedure is performed. Tr. 11/05/25 (Isaacson) at 30:14-23.

14. Prohibiting patients from being able to communicate "essential information" about their physical or mental condition can also undermine providers' ability to offer beneficial care and guidance to patients and thus is in tension with principles of beneficence, non-maleficence, and justice. Tr. 11/06/25 (Cunningham) at 68:15-69:15, 70:5-24.

15. Patients who are seeking abortion care after a fetal diagnosis often are suffering the loss of a desired pregnancy and require extra empathy, compassion, and understanding. Tr. 11/05/25 (Isaacson) at 29:11-20; *see* Tr. 11/06/25 (Wenstrom) at 24:21-25:1. These patients frequently feel overwhelming grief and "a tremendous feeling of guilt that somehow they did something wrong [and] their body failed them." Tr. 11/06/25 (Wenstrom) at 24:18-25:10. Yet, without knowing about the diagnosis, abortion providers cannot reassure patients experiencing these feelings. Tr. 11/05/25 (Isaacson) at 31:6-16. Instead, the Reason Ban amplifies feelings of guilt by making the patient keep the reason for their abortion a secret from their provider and making them feel like they are doing something wrong. Tr. 11/06/25 (Wenstrom) at 32:18-33:3.

16. The Reason Ban prevents patients from receiving information that may be valuable to future pregnancies, such as by electing a fetal autopsy. Tr. 11/06/25 (Wenstrom) at 36:4-6, Particularly in cases where an exact diagnosis is not available prenatally, fetal autopsies offer an opportunity to determine the cause of the fetal anomaly and understand its potential impact on future pregnancies. Tr. 11/06/25 (Wenstrom) at 24:7-17. Fetal autopsies thus can be "extremely helpful" to patients in providing assurances that a fetal condition is unlikely to reoccur or that there is a "strategy [available] for preventing it from happening again." *Id.* at 24:1-26:10. *See also* Tr. 11/05/25 (Isaacson) at 31:6-16 ("I would like to talk about what the recurrence [risk] of the condition is [with patients.]").

The Two-Trip and Mandatory Testing Requirements

17. The Two-Trip Requirement forces every patient to make at least two in-person trips to a doctor at least 24 hours apart before they can receive abortion care. A.R.S. §§ 36-2153(A), (F), 36-2158(A), 36-2156(A), 36-2162.01, 36-449.03(D)(3)(c), (G)(5); A.A.C. R9-10-1509(A)(3)(b), (A)(4), (B), (E)(1). It does so through a collection of statutory and regulatory requirements.

18. First, the Two-Trip Requirement mandates that every patient seeking abortion care undergo an ultrasound at least 24 hours before "any part of an abortion [is] performed," including "the administration of any . . . medication in preparation for the abortion." A.R.S. § 36-2156(A)(1);

A.A.C. R9-10-1509(A)(4) (incorporating A.R.S. § 36-2156 ultrasound requirement); A.R.S. § 36-2162.01.

19. Second, the Two-Trip Requirement compels the doctor performing the abortion or a referring physician to deliver certain state-mandated information to every patient orally and *in person*, at least 24 hours before an abortion, including "the probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed." A.R.S. § 36-2153(A)(1). It further mandates that "the physician who is to perform the abortion, the referring physician" or certain qualified professionals "to whom the responsibility has been delegated by either physician" recite additional information to the patient, orally and in person, at least 24 hours before an abortion. A.R.S. § 36-2153(A)(2). This information includes, but is not limited to, that:

- "Medical assistance benefits may be available for prenatal care, childbirth and neonatal care."
- "The father of the unborn child is liable to assist in the support of the child, even if he has offered to pay for the abortion."
- "Public and private agencies and services are available to assist the woman during her pregnancy and after the birth of her child if she chooses not to have an abortion, whether she chooses to keep the child or place the child for adoption."
- "The department of health services maintains a website that describes the unborn child and lists the agencies that offer alternatives to abortion."
- "The woman has the right to review the website and that a printed copy of the materials on the website will be provided to her free of charge if she chooses to review these materials."

A.R.S. § 36-2153(A)(2).

20. Additionally, patients seeking an abortion after a lethal or nonlethal fetal diagnosis must receive state-mandated information orally and *in person* at least 24 hours before an abortion. A.R.S. § 36-2158(A). This includes, for patients with lethal fetal conditions, information about the availability of perinatal hospice services, *id.* § 36-2158(A)(1), and, for patients with a non-lethal fetal condition, "information concerning the range of outcomes for individuals living with the

diagnosed condition, including physical, developmental, educational and psychosocial outcomes," and the availability of resources to assist the patient and their child, including adoption agencies, *id.* § 36-2158(A)(2).

21. Third, the Two-Trip Requirement mandates that before having an abortion, all patients who do not have "written documentation of blood type acceptable to the physician" undergo Rh testing. A.R.S. § 36-449.03(D)(3), (G)(5); A.A.C. R9-10-1509(A)(3)(b), (B).

22. Failure to comply with these mandates risks severe professional and civil penalties, including loss or suspension of a physician's license. A.R.S. §§ 36-2153(J)-(L), 36-2156(B)-(D), 36-2158(C)-(E). An abortion clinic that is not in "substantial compliance" with the Rh typing requirement may be subject to a range of civil penalties, including, among others, a fine of up to $1,000 per violation, reduction or termination of services, and suspension or revocation of the clinic's license. A.R.S. § 36-449.03(J)(1).

23. Due to the Two-Trip Requirement, *every* patient is forced to wait 24 hours after their first visit to obtain abortion care. Tr. 11/05/25 (Richardson) at 171:23-172:2; Tr. 11/05/25 (Mercer) at 85:18-23; Tr. 11/05/25 (Isaacson) at 21:22-22:4. In practice, the Two-Trip Requirement causes longer delays, Tr. 11/05/25 (Richardson) at 172:3-13, often one or more weeks, Tr. 11/05/25 (Mercer) at 92:6-17. *See also* Tr. 11/07/25 (Biggs) at 208:14-18 ("[W]hat we know from other states, [is] that . . . it's usually not 24 hours. It can often be a week because you're trying to schedule.").

24. Patients face challenges in attending two separate appointments at least 24 hours apart, such as needing to travel significant distances, take time off work, obtain childcare, arrange transportation and lodging, and pay for the associated costs. Tr. 11/05/25 (Richardson) at 171:8-16, 172:3-8, 193:2-14; Tr. 11/05/25 (Mercer) at 92:6-14; Tr. 11/05/25 (Isaacson) at 27:22-28:2; *see also* Tr. 11/07/25 (Biggs) 208:9-13. Moreover, the cost of abortion increases as pregnancy progresses, so the mandatory delay forces some patients to pay more to access the care itself. Tr. 11/07/25 (Biggs) 208:11-13. *See also* Tr. 11/05/25 (Isaacson) at 59:1-9.

25. Some patients cannot access medication abortion when that is their chosen method because the mandatory delay pushes them past the gestational limit for that care. Tr. 11/05/25 (Isaacson) at 28:3-5; Tr. 11/05/25 (Richardson) at 173:14-25 (estimating this occurs a couple times per week at CWC). Others are pushed past the clinic's gestational limit on abortion altogether. Tr. 11/05/25 (Isaacson) at 28:6-8. And some patients are unable to return to obtain their abortion due to the barriers imposed by the mandatory delay. Tr. 11/05/25 (Richardson) at 172:14-17, 173:11-13, 193:15-21 (estimating this occurs several times per week and ten or fifteen times per month).

26. The mandatory delay restricts abortion by reducing clinics' capacity to see patients. Tr. 11/05/25 (Richardson) at 174:7-14. Clinics are forced to divert resources to provide every abortion patient a separate appointment at least 24 hours before their abortion when they could otherwise offer abortion care to some patients in a single visit. *Id.* This makes it harder for patients to access care. Tr. 11/06/25 (Cunningham) at 92:3-93:13; *see* Tr. 11/05/25 (Richardson) at 174:7-14.

27. The mandatory ultrasound requires patients to obtain an ultrasound at least 24 hours in advance of the abortion appointment, regardless of medical necessity and regardless of patients' wishes. Tr. 11/05/25 (Isaacson) at 22:10-15; Tr. 11/05/25 (Richardson) at 171:23-172:8, 174:24-175:4; Tr. 11/05/25 (Mercer) at 85:18-23. Absent this requirement, patients could either forgo an ultrasound or have one performed right before the abortion procedure, depending on medical circumstances. Tr. 11/05/25 (Richardson) at 175:5-13; Tr. 11/05/25 (Mercer) at 87:2-13.

28. The mandatory Rh testing imposes a medically unnecessary testing requirement and additional delay. Rh testing determines whether a patient has an Rh antigen, which can result in certain complications for patients who are pregnant *beyond* 12 weeks gestation unless they are administered a shot of immune globulin (RhoGAM). Tr. 11/05/25 (Mercer) at 87:18-22, 103:12-104:15. As a result, clinical guidelines recommend Rh testing for abortion patients at 12 weeks gestation or greater. Regardless of the point in gestation, however, the Two-Trip Requirement forces every patient to undergo Rh testing before obtaining an abortion. Tr. 11/05/25 (Richardson) at 172:3-13; Tr. 11/05/25 (Isaacson) at 64:24-65:8.

29. Rh testing must be done by a high-complexity lab, and such a certification would be "prohibitively onerous and expensive" for an abortion clinic to obtain. Tr. 11/05/25 (Isaacson) at 65:9-15, 65:23-25. Receiving results from an outside lab can take more than 24 hours. Tr. 11/05/25 (Richardson) at 172:3-13. As such, in practice, the mandatory Rh testing requirement imposes additional delays on access to care. *Id.*

30. The mandatory information compels all patients to receive the same information as a condition of obtaining an abortion.

31. Providers must share with virtually all patients the same litany of information, orally and in person, including but not limited to: the point in gestation and physiologic development of the embryo or fetus, the risks associated with full-term childbirth, the availability of public and private assistance benefits, that the father of the child is required to support the child even if he offers to pay for the abortion, and that they may determine the disposition of the fetal remains. Tr. 11/05/25 (Isaacson) at 22:16-23:12; Tr. 11/05/25 (Richardson) at 175:14-176:4. In

addition, providers are forced to inform patients of the existence of a website maintained by ADHS that provides information about fetal development. Tr. 11/05/25 (Isaacson) at 22:16-23:12; *see also* ADHS, *A Women's* [sic] *Right to Know* (PX-145) ("State Pamphlet"); ADHS, *A Woman's Right to Know, Statewide Resources Arizona – 2014* (PX-147).

32. Patients are required to listen to the mandatory information even when they request not to hear it, and even when it is upsetting to them. Tr. 11/05/25 (Richardson) at 176:5-16; Tr. 11/05/25 (Isaacson) at 25:16-26:3.

33. Patients must receive the mandatory information when it is irrelevant to them. Tr. 11/05/25 (Richardson) at 190:22-191:7; Tr. 11/06/25 (Cunningham) at 78:14-79:10. For example, that the father must pay child support is irrelevant to patients where the father is unknown or deceased. Tr. 11/06/25 (Cunningham) at 78:11-79:6. Information about fetal development for a pregnancy of a specific gestation is irrelevant to a patient with a fetal anomaly that makes that description untrue for their pregnancy. *Id.* And adoption is not a realistic option for many patients with fetal diagnoses. Tr. 11/06/25 (Wenstrom) 126:20-127:3, 127:14-17.

34. This requirement forces patients to wait at least 24 hours from the time of their first appointment, even when they are certain they want to proceed and have already considered their options. Tr. 11/05/25 (Isaacson) at 27:19-25; Tr. 11/05/25 (Mercer) at 109:4-8; 11/07/25 (Biggs) at 208:2-8. In doing so, the mandatory delay infringes on patients' decision-making autonomy. Tr. 11/05/25 (Mercer) at 94:25-95:2; Tr. 11/05/25 (Nichols) at 128:12-21; 11/07/25 (Biggs) at 207:12-19; *see also* Tr. 11/06/25 (Cunningham) at 72:16-73:2 (explaining that the principle of autonomy does not support mandatory delays); Tr. 11/07/25 (Biggs) at 208:6-8 ("Being forced to wait . . . is coercive in and of itself. You're forcing someone to do something they don't want."). Indeed, even Intervenors' medical ethics expert described the act of imposing a waiting period on a patient certain in their decision and wanting to move forward with treatment as "overrid[ing] their decision." Tr. 11/07/25 (Collier) at 29:17-30:6.

35. The mandatory delay overrides some patients' decisions about abortion care. Tr. 11/05/25 (Richardson) at 173:14-25. *See also* Tr. 11/06/25 (Nelson) at 238:20-239:18. Some patients are unable to obtain their abortion at all. Others cannot obtain the type of abortion they elected (medication abortion) and, if they wish to obtain an abortion, are instead forced to undergo a procedural abortion that they do not want. Tr. 11/05/25 (Richardson) at 173:14-25.

36. **Mandatory ultrasound and Rh testing:** The right to refuse medical care is a component of autonomy. Tr. 11/06/25 (Cunningham) at 79:17-24. This includes the right to refuse a medical intervention. Tr. 11/07/25 (Collier) at 61:6-8; *see* ACOG Committee Opinion 819 (PX-

40 at 1) ("An adult patient with decision-making capacity has the right to refuse treatment, including during pregnancy . . . ."). Nevertheless, Arizona law requires patients to undergo an ultrasound and Rh testing as a prerequisite for obtaining an abortion, regardless of medical necessity and even over their objections. Tr. 11/05/25 (Richardson) at 174:24-175:4 (explaining patients have tried to decline the mandatory ultrasound); Tr. 11/05/25 (Mercer) at 87:14-17, 87:23-24 (explaining Rh testing is required in Arizona though not medically indicated before every abortion). *See also* Tr. 11/06/25 (Wenstrom) at 40:25-41:5 (patients have declined first trimester ultrasounds). These testing requirements conflict with autonomous decision making. Tr. 11/05/25 (Nichols) at 128:22-129:10.

37. **Mandatory information:** The right to refuse medical care as a component of autonomy includes the right to refuse to receive information during the informed consent process. Tr. 11/06/25 (Cunningham) at 79:17-24. Sharing information that a patient has requested not to hear can violate autonomy. *Id.* at 98:25-99:12. Therefore, if a patient communicates that they do not wish to receive certain information, "the appropriate thing to do is to not disclose" that information and "to respect that patient's choice." *Id.* at 79:14-24, 80:8-24. *See also* ACOG Committee Opinion 819 at e34 (PX-40 at 1) (informed consent information should be presented "in keeping with the patient's preferences for receiving information").

38. The mandatory information infringes on autonomous decision making for further reasons. Providing information that is immaterial to the specific, individualized patient violates autonomy. Tr. 11/06/25 (Cunningham) at 98:12-18. Instead of receiving information from their providers in a way that is tailored to their unique circumstance and needs to enable them to make an informed, authentic choice about their medical care, patients are forced to work through superfluous, irrelevant information to try and determine what information is applicable to them before they can make an informed decision. *Id.* at 78:14-79:10.

39. Providing mandatory information that patients find harmful places the doctor in a position of appearing to dissuade patients from having an abortion. Tr. 11/05/25 (Isaacson) at 26:4-12.

40. The in-person requirement for receiving the mandatory information infringes on autonomous decision making because it deprives patients of the option of receiving information through telemedicine. Tr. 11/06/25 (Cunningham) at 83:6-84:25; Tr. 11/05/25 (Richardson) at 178:2-11, 178:17-19, 179:4-10; Tr. 11/05/25 (Mercer) at 91:6-21.

41. Forcing patients to remain pregnant by delaying or denying abortion care prolongs and can exacerbate pregnancy symptoms, such as hyperemesis gravidarum (severe nausea and vomiting). Tr. 11/05/25 (Mercer) at 93:7-14. *See also* Tr. 11/06/25 (Cunningham) at 70:25-71:15 (patients face harm from continued gestation due to lack of access to abortion, which is inconsistent with medical ethics).

42. Delays can make medication abortion less effective, cause more pain and bleeding, and even push patients past the gestational cut-off for that method and require them instead to undergo a more invasive procedural abortion. Tr. 11/06/25 (Nelson) at 238:12-239:18; Tr. 11/05/25 (Richardson) at 173:14-23. Delaying abortion care can cause patients additional mental and emotional distress, particularly for those who may be pregnant due to sexual assault. Tr. 11/05/25 (Mercer) at 94:13-22.

43. Patients who are prevented from accessing abortion altogether have been shown to have worse health outcomes than those who obtained an abortion. ACOG *Increasing Access to Abortion* at e88 (PX-41 at 3); Tr. 11/07/25 (Biggs) at 194:24-202:18. This includes the significantly greater risks of carrying a pregnancy to term. *See* FOF ¶¶ 74-75; ACOG, *Statement on Reason Bans* at 1 (PX-45 at 1) ("[F]orcing women to carry pregnancies to term, regardless of their reasons for needing an abortion . . . will compel high-risk women to endanger their lives, increasing maternal mortality."); *cf.* Tr. 11/07/25 (Nelson) at 219:23-221:25 (admitting that risks from certain medical and surgical interventions associated with pregnancy exceed risk of abortion).

44. This also includes worse mental health outcomes. The Turnaway Study compared outcomes for women seeking an abortion who were able to obtain one with outcomes for women seeking an abortion who were denied one because they were beyond the gestational limit. Tr. 11/07/25 (Biggs) at 195:7-17. Researchers followed women from the moment of being denied an abortion through interviews every six months over five years. *Id.* at 192:12-23, 195:24-196:11. The Turnaway Study found that people who were denied an abortion showed "more symptoms of anxiety, as well as more stress and lower self-esteem" at the moment of being denied an abortion and for six months thereafter. *Id.* at 198:12-16. Further, Turnaway research showed that people who were denied an abortion were more likely to remain tethered to a violent partner, whereas people who had an abortion were more likely to cease contact with an abusive partner. *Id.* at 212:18-213:22.

45. The Turnaway Study has resulted in more than 50 peer-reviewed publications in leading journals, and its lead researcher, Diana Greene Foster, received a MacArthur Fellowship, which is considered one of the highest honors in academia, for her work on it. Tr. 11/07/25 (Biggs)

at 199:3-17. The Court finds the Turnaway Study's conclusions regarding mental health outcomes both reliable and persuasive.

The Telemedicine Ban

46. The Telemedicine Ban provides that "[a] health care provider shall not use telehealth to provide an abortion," A.R.S. § 36-3604(A). It also imposes a mailing ban that prohibits "a manufacturer, supplier or physician or any other person . . . from providing an abortion-inducing drug via courier, delivery or mail service." A.R.S. § 36-2160(B); *see also id.* § 36-2160(D) (defining "abortion-inducing drug" as "a medicine or drug or any other substance used for a medication abortion")[4].

47. A physician who knowingly violates this express ban "commits an act of unprofessional conduct and is subject to license suspension or revocation." A.R.S. § 36-3604(B). A clinic provider who violates the mailing ban may be fined up to $1,000 per violation, per day and per patient affected. A.R.S. § 36-431.01. And a licensed abortion clinic that is not "in substantial compliance with" the requirements to conduct an in-person physical exam, ultrasound, or laboratory tests may be fined up to $1,000 per violation per day by ADHS and face sanctions such as termination of services and revocation, denial, or suspension of its facility license. A.R.S. §§ 36-449.03(J)(1), 36-431.01, 36-427.

48. The Telemedicine Ban singles out abortion patients and deprives them of the autonomous choice to access abortion care, where appropriate, via telemedicine. Tr. 11/05/25 (Richardson) at 178:2-11; Tr. 11/06/25 (Cunningham) at 83:15-84:4, 84:17-25.

49. Clinical standards of practice and evidence-based medicine do not support a ban on telemedicine use for medication abortion. Tr. 11/05/25 (Mercer) at 97:14-21; Tr. 11/06/25 (Cunningham) at 83:6-12, 84:5-8. Indeed, ACOG has specifically denounced such bans because they "create barriers to abortion access or interfere with the patient-health care professional relationship and the practice of medicine[.]" ACOG *Increasing Access to Abortion* at e86 (PX-41 at 1). *See* Tr. 11/05/25 (Nichols) at 150:3-15; *see also* FOF ¶ 86 (telemedicine makes abortion more accessible).

[4] The Telemedicine Ban also includes an in-person physical examination, ultrasound, laboratory tests, and state-mandated information requirements, many of which overlap with the Two-Trip Requirements and make telemedicine abortion care impossible, A.R.S. §§ 36-449.03(D), 36-2156(A), 36-2153(A), 36-2158(A); A.A.C. R9-10-1509(A)-(D), (E)(1), R9-10-1501(8),

50. Telemedicine abortion is safe and effective, based on accepted clinical standards of practice and evidence-based medicine. "Telemedicine can be safely used to provide abortion care, including medication abortion provision, informed consent, and follow-up." NAF 2024 Guidelines at 1 (PX-105 at 1).

51. The complication rates for medication abortion, whether delivered in person or through telemedicine, are comparable and extremely low. Tr. 11/05/25 (Mercer) at 96:1-4. Providers can effectively screen patients over telemedicine to determine eligibility for medication abortion through detailed history taking. Tr. 11/05/25 (Richardson) at 179:1-13; Tr. 11/06/25 (Nichols) at 150:25-152:5. In circumstances where screening suggests telemedicine abortion might be inappropriate for a patient, a provider can then direct them to an in-person visit. Tr. 11/05/25 (Richardson) at 179:4-13; Tr. 11/05/25 (Mercer) at 102:18-103:2.

52. Dr. Nelson testified that the Telemedicine Ban protects patients who cannot accurately report their last menstrual period (LMP) and who have ectopic pregnancies. Tr. 11/06/25 (Nelson) at 145:19-146:7. However, precise dating is not medically necessary for early medication abortion. Dr. Nelson supplied no literature or clinical standards to support the claim that providers will be unable to screen for ectopic pregnancy risk factors (and thus determine whether additional testing is necessary) via telemedicine. Tr. 11/06/25 (Nelson) at 136:14-137:16.

53. Ectopic pregnancies are rare, occurring in fewer than 1% of patients. Tr. 11/05/25 (Nichols) at 142:5-10. And ectopic pregnancies in early gestations are often too small to even be visualized on an ultrasound. *Id.* at 144:9-14. Nevertheless, providers can effectively screen for ectopic pregnancy using telemedicine. Tr. 11/05/25 (Richardson) at 179:25-180:5 ("[T]he research has shown that there's parity between seeing patients in person and providing telemedicine in terms of diagnosing ectopic pregnancy."). Providers can screen for ectopic pregnancy via telemedicine through a detailed history taking which asks patients about the timing of their LMP and initial symptoms of pregnancy, and about risk factors such as previous ectopic pregnancies, tubal surgery, previous sexually transmitted infections, and location of any abdominal pain. *Id.* at 179:14-24. *See* Tr. 11/05/25 (Nichols) at 142:11-19.

54. An early medication abortion can actually help a provider diagnose an ectopic pregnancy. Tr. 11/05/25 (Nichols) at 143:8-20. Unlike in a uterine pregnancy, a patient with an ectopic pregnancy would experience very little or no bleeding and cramping after taking medication abortion because the medication would not work to terminate the pregnancy, which would signal that further diagnostic testing might be needed. *Id.* at 143:8-23.

55. Providers can effectively obtain informed consent for medication abortion via telemedicine. Tr. 11/05/25 (Nichols) at 148:2-19; Tr. 11/05/25 (Richardson) at 181:4-10; *see* Tr. 11/06/25 (Cunningham) at 82:25-83:5, 83:13-18 (testifying that in-person visits do not generally ensure better comprehension of informed consent materials and obtaining informed consent over telemedicine is consistent with medical ethics). Providers can meet with the patient, take their relevant medical history, inform the patient of their options, confirm that the patient understands the information being relayed, and then provide next steps via telehealth, as they already do for telemedicine care outside the abortion context. Tr. 11/05/25 (Mercer) at 97:3-10.

Abortion: Procedures and Risks

56. Abortion is common. Tr. 11/05/25 (Mercer) at 76:20-21. Approximately 25% of women will have an abortion in their lifetime. *Id.* at 76:22-25; ACOG, *Practice Bulletin No. 225: Medication Abortion Up to 70 Days of Gestation*, 136(4) Obstetrics & Gynecology e31 (Oct. 2020) ("ACOG Bulletin 225") (PX-43 at 1).

57. Patients seek abortion care for a variety of reasons. Tr. 11/05/25 (Mercer) at 77:1-25. For example, some patients may feel that they cannot support another child in addition to their existing children and wish to limit the growth of their family. *Id.* at 77:7-10. Other patients may decide that it is not the right time to become a parent because of education, work, or other obligations. *Id.* at 77:11-13. And some patients seek abortion because they are looking to escape an abusive relationship and avoid being tethered to that abusive partner. *Id.* at 77:4-7.

58. Some patients seek to end a desired pregnancy. Tr. 11/05/25 (Mercer) at 77:17-19. That can be because the patient has a medical complication, or because a fetal diagnosis has been made. *Id.* at 77:20-25; Tr. 11/05/25 (Isaacson) at 29:11-20.

Availability of Abortion Care in Arizona

59. Patients in Arizona face challenges in accessing abortion care. Abortion care is mainly available in Phoenix and Tucson, forcing patients in Arizona's many rural counties to travel significant distances to access care. Tr. 11/05/25 (Mercer) at 93:15-25; Tr. 11/05/25 (Richardson) at 170:17-171:1, 171:8-16; *see also* Tr. 11/05/25 (Isaacson) at 29:21-30:6 (Arizona abortion providers who provide care at gestational ages where fetal conditions are likely to have been detected are located in Phoenix), 31:21-32:6 (testifying that he chose to primarily provide abortion care because it was clear there were not enough providers).

60. Patients also face financial barriers to access. This can include the need to take time off from work, locate childcare, and arrange transportation. Tr. 11/05/25 (Isaacson) at 27:19-28:2; Tr. 11/05/25 (Mercer) at 93:15-25; Tr. 11/05/25 (Richardson) at 171:8-16.

Abortion Procedures

61. The most common abortion method in the United States is medication abortion, followed by procedural abortion (surgical abortion). Tr. 11/05/25 (Mercer) at 78:1-4; Tr. 11/05/25 (Richardson) at 173:21-23. Medication abortion typically refers to a regimen of two medications, mifepristone and misoprostol, to terminate a pregnancy. Tr. 11/05/25 (Mercer) at 78:5-10, 83:8-14. The patient first takes mifepristone, which acts as an antiprogestin, breaks down the uterine lining supporting the pregnancy, and softens the cervix. *Id.* at 78:5-10; ACOG Bulletin 225 at e31 (PX-43 at 1). Within 48 hours, they then take misoprostol, which causes further cervical softening and uterine contractions. Tr. 11/05/25 (Mercer) at 78:5-10; ACOG Bulletin 225 at e31 (PX-43 at 1). Ordinarily, these medications will cause a patient to experience bleeding and cramping and to pass the pregnancy. Tr. 11/05/25 (Nichols) at 143:12-16. This same medication regimen is used to treat a miscarriage, also referred to as a spontaneous abortion. Tr. 11/05/25 (Mercer) at 78:11-16.

62. This medication regimen is supported by major medical organizations nationally and internationally, ACOG Bulletin 225 at e31 (PX-43 at 1), and 99.9% of non-procedural abortions in Arizona use mifepristone and misoprostol, Tr. 11/05/25 (Mercer) at 78:5-10; ADHS, *Abortions in Arizona: 2023 Abortion Report* 22 (Dec. 18, 2024) (PX-48 (Table 11)). Medication abortion is generally available up to 11 weeks in Arizona. Tr. 11/05/25 (Isaacson) at 14:24-15:1; Tr. 11/05/25 (Richardson) at 168:3-6.

63. In a procedural abortion, medical instruments and suction are used to empty the uterus. Tr. 11/05/25 (Mercer) at 83:15-19. This same procedure is also used to treat a miscarriage. *Id.* at 83:20-23.

64. Procedural abortion is used at greater gestations than medication abortion. *See* Tr. 11/05/25 (Isaacson) at 14:24-15:1.

65. Most patients who are eligible for medication abortion choose that method over procedural abortion. Tr. 11/05/25 (Nichols) at 130:14-20. Patients may prefer medication abortion because it feels less invasive or more natural or because it allows them to pass their pregnancy more privately at home. *Id.* at 130:6-17*;* ACOG Bulletin 225 at e31 (PX-43 at 1). In particular, avoiding a more invasive procedure can be preferable for survivors of sexual trauma or intimate partner violence. Tr. 11/05/25 (Nichols) at 130:21-131:1.

66. While both medication and procedural abortion are safe, for some patients, medication abortion can be a safer method than procedural abortion. Tr. 11/05/25 (Nichols) at 131:2-14. This can occur, for example, where a patient has a certain anatomy of the cervix and lower uterine segment or fibroids, which make it more difficult to insert an instrument into the patient's uterine cavity. *Id.* at 131:2-11; ACOG Bulletin 225 at e32 (PX-43 at 2).

Risks of Abortion and Childbirth

67. Abortion is one of the most extensively studied treatments in medicine. Tr. 11/05/25 (Mercer) at 84:13-16. Its safety has been established by substantial medical research authored by experienced researchers, published in well-respected, peer reviewed journals, and reviewed and endorsed by organizations that specialize in women's health, like ACOG. Tr. 11/05/25 (Nichols) at 131:12-132:4.

68. Serious complications following an abortion are very rare. Tr. 11/05/25 (Mercer) at 84:17-20. A large study published in a peer-reviewed journal found that only 0.23% of medication abortion patients, 0.16% of first trimester procedural abortion patients, and 0.41% of second trimester abortion patients experienced a major complication. *Id.* at 136:20-137:4.

69. Abortion is safer than carrying a pregnancy to term. Tr. 11/05/25 (Nichols) at 139:14-140:9; *see also* Tr. 11/05/25 (Mercer) at 85:3-5. As ACOG has recognized, abortion is safe at all gestational ages and the overall risk of complications is low and "far outpaced by comparable complication rates of childbirth for every complication type." ACOG, *Committee Statement No. 16: Increasing Access to Abortion*, 145(2) Obstetrics & Gynecology e89, e92 (Feb. 2025) ("ACOG *Increasing Access to Abortion*") (PX-41 at 4, 7).

70. Data from the U.S. Department of Health and Human Services ("HHS") confirms that the mortality rate for pregnancy and childbirth is over ten times that for abortion. Tr. 11/05/25 (Nichols) at 138:8-139:9.

71. Pregnancy and childbirth also carry significant complication risks, such as blood loss requiring transfusion, infection, and complications requiring a surgical delivery (C-section). Tr. 11/05/25 (Nichols) at 139:17-140:1; Tr. 11/06/25 (Nelson) at 219:16-220:11. HHS recently reported that 30,000 women annually experience severe complications from pregnancy and childbirth. Tr. 11/05/25 (Nichols) at 140:15-141:20; 2024 HHS Report at 11 (PX-133 at 11); *see also* ADHS, *Maternal Mortalities & Severe Maternal Morbidity in Arizona* 6 (Dec. 2020) (PX-49 at 8) ("Each year in Arizona, approximately 70 women die within 365 days of pregnancy, of which 15-20 deaths are pregnancy-related cases (i.e., would not have died if she had not been pregnant).

Additionally, approximately 900 women experience a severe maternal morbidity ("SMM") during labor and delivery in an Arizona hospital (i.e., a severe and unexpected complication).").

72. The general consensus of the scientific community is that abortion does not cause negative mental health outcomes. Tr. 11/07/25 (Biggs) at 184:11-185:7. For example, the American Psychological Association ("APA"), which is the leading organization of professional psychologists in the United States, concluded in a 2008 report that "[t]he best scientific evidence published indicates that among adult women who have an unplanned pregnancy, the relative risk of mental health problems is no greater if they have a single elective first trimester abortion than if they deliver that pregnancy." *Id.* at 187:1-11 (quoting Major, B. et al., *Report of the APA Task Force on Mental Health Abortion* 4 , Am. Psych. Ass'n Task Force on Mental Health & Abortion (2008)). The Royal College of Psychiatrists, the leading professional body of psychiatrists in the United Kingdom, likewise concluded that "[w]hen a woman has an unwanted pregnancy, rates of mental health problems will be largely unaffected whether she has an abortion or goes on to give birth." Tr. 11/07/25 (Biggs) at 187:12-15, 189:1-17 (quoting Nat'l Collaborating Ctr. for Mental Health, *Induced Abortion and Mental Health: A Systematic Review of the Mental Health Outcomes of Induced Abortion, Including Their Prevalence and Associated Factors*, Acad. Med. Royal Colls. 125 (2011)).

Fetal Testing and Counseling

73. Fetal abnormalities are typically detected by ultrasound, and generally in the second trimester. Tr. 11/06/25 (Wenstrom) at 18:5-24, 39:2-5. Patients may first have a screening test, which determines whether a fetus is at increased risk of developing a certain condition, followed by a diagnostic test, which confirms whether the fetus actually has that condition. *Id.* at 19:1-8.

74. Counseling for pregnant patients throughout the process of testing for a fetal abnormality is critical to ensuring patients have the information and support they need. Some patients may be confused about the meaning of screening tests, believing that they are the same as a confirmed diagnosis. Tr. 11/06/25 (Wenstrom) at 19:9-20:12. Open communication between patients and providers is necessary to address this confusion. *Id.* at 20:13-21:6.

75. After a positive fetal diagnosis, providers counsel patients, "in as neutrally fact-based way possible," explaining the condition and asking questions to ensure the patient understands the information. Tr. 11/06/25 (Wenstrom) at 21:7-15. Counseling also involves getting to know the patient, their background, why they had the testing, and what they understand about the result. *Id.* at 21:16-22:6. Providers then ask, in a nondirective (i.e. neutral) way, whether the patient would like to know their options; if they say yes, providers explain those options, also in a nondirective way. *Id.* at 22:6-11. Throughout the counseling process, the provider's goal is to

provide emotional support to patients in an extremely difficult time while remaining as neutral as possible until they have reached a decision. *Id.* at 22:16-23. Providers then give as much support as possible to the patient, whether they decide to continue a pregnancy or terminate. *Id.* at 23:20-25.

Telemedicine Safety and Benefits

76. Health care providers use telemedicine to provide a broad array of essential care, including in Arizona. Tr. 11/05/25 (Mercer) at 96:5-15; Tr. 11/05/25 (Nichols) at 146:2-14. For example, providers regularly use telemedicine to counsel patients about family planning, contraception, and prenatal care. Tr. 11/05/25 (Nichols) at 146:2-14.

77. As part of this care, providers use telemedicine to obtain informed consent. Tr. 11/05/25 (Nichols) at 146:15-147:9; Tr. 11/05/25 (Mercer) at 89:12-90:8; Tr. 11/06/25 (Cunningham) at 82:25-83:2. This includes obtaining informed consent for major surgeries with potentially permanent implications and significant patient decision-making components, such as hysterectomies, tubal ligations, and c-section deliveries. Tr. 11/05/25 (Nichols) at 146:15-147:9; Tr. 11/05/25 (Mercer) at 89:12-90:8. *See also* Tr. 11/06/25 (Cunningham) at 84:9-16 (explaining that, as a clinical ethicist, he uses telemedicine to have phone conversations with providers, patients, and/or family members to resolve complicated ethical issues).

78. Where appropriate, telemedicine provides significant benefits to patients and providers. It allows health care providers to communicate with patients in a manner that is best for the patient. 11/06/25 (Cunningham) at 83:20-84-4, 84:17-25. Patients are able to consult with their provider from the comfort and privacy of their own environment. Tr. 11/05/25 (Mercer) at 89:19-90:8. Telehealth also enables friends or family to be present, where the patient so desires, to reassure the patient and to help them in their process of taking in medical information and making decisions about how to proceed. *Id.*; Tr. 11/05/25 (Nichols) at 146:15-147:9. Telehealth further allows for delivery of care to patients who may be unable to access in-person care, such as those who reside in remote areas and/or who lack financial resources, transportation access, and childcare. Tr. 11/05/25 (Nichols) at 147:13-23; Tr. 11/05/25 (Mercer) at 96:5-15; Tr. 11/05/25 (Richardson) at 178:5-11. And telemedicine increases the efficiency of the healthcare system by facilitating the provision of care to the community and decreasing overhead costs for health care facilities. Tr. 11/05/25 (Mercer) at 96:16-22.

79. Arizona has a general framework governing how clinicians use telemedicine, including for informed consent, that ensures patient safety is not compromised. All clinicians are required to use their best clinical judgment regarding whether a particular medical case is

appropriately treated using telemedicine, and to assess what type of telemedicine technology is appropriate for that interaction. Tr. 11/06/25 (Nelson) at 242:10-17. They are likewise required to obtain the patient's informed consent both for the treatment itself *and* specifically for the provision of that treatment using telemedicine. *Id.* at 242:21-243:3. If a provider fails to follow these requirements or otherwise engages in unprofessional conduct while providing care through telemedicine, they are subject to disciplinary action by the Arizona Medical Board, as well as potential malpractice liability. *Id.* at 243:4-12, 212:22-213:11.

80. As of 2024, medication abortion is available by telehealth in 20 states. Tr. 11/05/25 (Nichols) at 151:5-11.

81. Whether patients communicate with their provider in person or using telemedicine before having a medication abortion does not affect the quality of care they receive. Tr. 11/05/25 (Nichols) at 147:24-149:11. Either way, providers explain the process; answer questions; give specific instructions for taking the medications; explain what patients can expect in terms of the effects of the medication, how to manage those effects, and how to distinguish between the normal range of effects and any concerning symptoms; ask questions to confirm the patient has taken in the necessary information; and confirm that patients are speaking for themselves and giving voluntary consent. *Id.* at 148:5-149:3; *see also* Tr. 11/05/25 (Richardson) at 181:4-10. Either way, the patient takes the medications and ends their pregnancy outside the clinic. Tr. 11/05/25 (Richardson) at 180:13-23. And either way, providers give patients a 24/7 contact in case potential complications arise, Tr. 11/05/25 (Nichols) at 149:4-11; Tr. 11/05/25 (Richardson) at 180:6-12, and coordinate care with other providers, if needed, Tr. 11/05/25 (Richardson) at 180:6-12.

82. Whether patients communicate with their provider in person or using telemedicine before having a medication abortion also does not affect patient safety. As clinical standards recognize, "[m]edication abortion can be provided safely and effectively by telemedicine with a high level of patient satisfaction, and telemedicine improves access to early abortion care, particularly in areas that lack a health care practitioner." ACOG Bulletin 225 at e35 (PX-43 at 5); *see also id.* ("Patients who choose telemedicine medication abortion are significantly more likely to say they would recommend the service to a friend compared with those who have an in-person visit (90% versus 83%.)").

83. For abortion patients, "the privacy afforded by telemedicine is really valuable, particularly for patients who are concerned about going into a clinic where they might run into family or friends or colleagues." Tr. 11/05/25 (Nichols) at 149:12-24.

84. Telemedicine abortion can also make abortion accessible for patients who live in remote areas or who face financial or logistical barriers in visiting a clinic in person. Tr. 11/05/25 (Richardson) at 178:2-11. Peer-reviewed research confirms that, for many patients, telemedicine makes the difference between accessing timely abortion care or being delayed or prevented in accessing care. In one study, after providers initiated a telemedicine program, abortion rates increased for patients living more than 50 miles from an in-person clinic, indicating that telemedicine enabled more patients living far from clinics to access care. Tr. 11/05/25 (Nichols) at 152:6-153:18; *see also* ACOG Bulletin 225 at e35 (PX-43 at 5).

CONCLUSIONS OF LAW

The Standard of Review: Strict Scrutiny

85. Under the Amendment, "[e]very individual has a fundamental right to abortion." Ariz. Const. art. II, § 8.1(A). While courts ordinarily presume that the legislature acts constitutionally, "any presumption in [a law's] favor falls away" when it burdens a fundamental right. *Gallardo v. State*, 236 Ariz. 84, 87-88 ¶ 9 (2014).

86. Because the right to abortion is fundamental, any restrictions on that right are presumptively invalid. *Id.* Thus, the burden is on the government (here, Intervenors) to prove that the Challenged Laws are constitutional. *Id.*

87. The Amendment mandates that courts review laws that deny, restrict, or interfere with that right before fetal viability under a particularly stringent strict scrutiny standard; such laws must be "justified by a compelling state interest" "that is achieved by the least restrictive means." Ariz. Const. art. II, § 8.1(A)(1).

The Reason Ban

88. The Reason Ban denies and restricts the fundamental right to abortion by completely proscribing abortion care based on a patient's reason or seeking an abortion. Specifically, a woman is not entitled to a pre-viability abortion if her stated reason for the abortion is based on the race, gender or fetal abnormality.

89. Intervenors have not shown that the Reason Ban was adopted or enacted to further a compelling state interest. The Reason Ban fails both the patient health and patient autonomy tests of the Amendment.

90. The Reason Ban does not "improve or maintain" the health of a woman seeking an abortion. In fact, the Reason Ban can have negative physical and mental impacts on women who seek abortion care. *See* FOF ¶¶ 12-16.

91. The Reason Ban directly infringes on a woman's autonomous decision-making by completely proscribing an abortion based on specific reasons why a person might choose to have such a procedure. *See* FOF ¶¶ 7-11.

92. The Reason Ban infringes on a patient's autonomous decision-making in *all* situations because it applies across the board, thereby removing abortion as an option *before* the patient may even consider it.

93. The Reason Ban violates the fundamental right to abortion under Arizona's Constitution.

The Telemedicine Ban

94. The Telemedicine Ban restricts, interferes and denies the fundamental right to an abortion by completely proscribing a woman from obtaining an abortion through telemedicine.

95. Intervenors have not shown that the Telemedicine Ban is justified by a compelling state interest. The Telemedicine Ban fails both the patient health and patient autonomy tests of the Amendment.

96. The Telemedicine Ban does not "improve or maintain" the health of a woman seeking an abortion. *See* FOF ¶¶ 49-55. *Planned Parenthood of Montana v. State*, 570 P.3d 51, ¶ 87 (Mont. 2025)(mandatory 24-hour waiting period, multiple in-person visits and telehealth ban violate Montana's constitutional right of privacy as they "only make obtaining abortion care more difficult, more inconvenient, and more costly, without showing that they protect women's health.").

97. To the extent there is any medical benefit to the Telemedicine Ban, Intervenors have not shown that a complete ban is the least restrictive means to achieve that end. Telemedicine is used for a variety of medical procedures, and its use is regulated by the Arizona Medical Board. FOF, ¶¶ 76-79. Intervenors have not shown any reason for treating abortion differently, and completely banning the use of telemedicine for this procedure.

98. The Telemedicine Ban directly infringes on a woman's autonomous decision-making by removing as an option a safe and effective means of obtaining an abortion. *See also* FOF ¶ 48.

99. The Telemedicine Ban infringes on a patient's autonomous decision-making in *all* situations because it applies across the board, thereby removing a telemedicine abortion as an option *before* the patient may even consider it.

100. The Telemedicine Ban violates the fundamental right to abortion under Arizona's law.

The Two Trip, Mandatory Testing and Mandatory Disclosure Requirements

101. Arizona law requires every patient seeking an abortion undergo an ultrasound at least 24 hours before any part of an abortion is performed. A.R.S. § 36-2156(A)(1); A.A.C. R9-10-1509(A)(4).

102. Intervenors have not shown that requiring an ultrasound for every patient, 24 hours before the abortion, is the least restrictive means for ensuring that this test is performed when it is medically necessary. FOF ¶ 27.

103. Requiring an ultrasound for every patient directly infringes on a woman's autonomous decision-making by deciding for the patient that this test is necessary in all circumstances. FOF ¶ 36.

104. The ultrasound requirement infringes on a patient's autonomous decision-making in *all* situations because it applies across the board, thereby forcing the test on every patient *before* the patient may consider the risks and benefits of the test.

105. The ultrasound requirement violates the fundamental right to abortion under Arizona law.

106. Arizona law mandates that before having an abortion, all patients who do not have "written documentation of blood type acceptable to the physician" undergo Rh testing. A.R.S. § 36-449.03(D)(3), (G)(5); A.A.C. R9-10-1509(A)(3)(b), (B).

107. Intervenors have not shown that requiring Rh testing for *all* patients without written documentation of their blood type is the least restrictive means for ensuring that this test is performed when it is medically necessary. FOF ¶ 28.

108. Requiring an Rh test for every patient directly infringes on a woman's autonomous decision-making by deciding for the patient that this test is necessary in all circumstances. FOF ¶ 36.

109. The Rh test requirement infringes on a patient's autonomous decision-making in *all* situations because it applies across the board, thereby forcing the test on every patient *before* the patient may consider the risks and benefits of the test.

110. The ultrasound requirement violates the fundamental right to abortion under Arizona law.

111. The state-mandated disclosure in A.R.S. § 36-2153(A)(2) does not improve or maintain the health of a woman seeking an abortion. On the contrary, the purpose of the mandated disclosure is to discourage abortion and/or encourage the patient to choose childbirth. *See Northland Family Planning Center v. Nessel*, 2025 WL 2098474, *32 (Mich. Ct. of Claims, filed 5-13-2025) ("[T]he overwhelming medical consensus is that mandatory informed-consent schemes, enacted to persuade people to continue pregnancies . . . do not serve patient health and decision-making and are contrary to the standard of care.").

112. Mandating that the disclosure be in-person and at least 24 hours before an abortion causes delay, which increases the risk of abortion and sometimes prevents a woman from having an abortion altogether. FOF ¶¶ 23-25, 34-35 and 41-43. *Planned Parenthood of Montana,* 570 P.3d at ¶ 85.

113. To the extent there is any medical benefit to the patient from the mandated disclosure, Intervenors have not shown that requiring doctors to disclose specific information is the least restrictive means of achieving this benefit. The standard of care requires physicians to obtain informed consent from their patients regarding the risks of medical procedures. The Arizona Medical Board regulates informed consent practice for the vast majority of medical procedures without the need for state-mandated disclosure of information. Intervenors have shown no reason why the Arizona Medical Board is unable to regulate informed consent for abortion.

114. The state-mandated disclosure directly infringes on a woman's autonomous decision-making by requiring her doctor to provide information, and for her to receive it, regardless of whether it is relevant to her decision. FOF ¶¶ 37-40; *Northland Family Planning Center, supra,* *32 ("[T]he mandatory 24-hour waiting period infringes upon autonomous decision-making."); *Planned Parenthood of Montana,* 570 P.3d at ¶ 89 (state-mandated informed consent for abortion "intrudes on the personal autonomy privacy right in healthcare decisions.").

115. The state-mandated disclosure infringes on a patient's autonomous decision-making in *all* situations because it applies across the board, thereby forcing on every patient to

receive the same information regardless of whether it is relevant to them and whether they wish to receive it.

116. The state-mandated disclosure violates the fundamental right to abortion under Arizona law.

Severability

117. The court need not analyze severability because it finds that each of the Challenged Laws violates the Arizona Constitution as applied to pre-viability abortions.

Facial Challenge

Plaintiffs raise a facial challenge to the Challenged Laws. Intervenors, therefore, argue that Plaintiffs "must establish that no set of circumstances exists" under which the laws would be valid. *State v. Arevalo,* 249 Ariz. 370, 373 ¶ 10 (2020) (adopting the standard from *United States v. Salerno,* 481 U.S. 739 (1987). Intervenors assert that *some* of the Challenged Laws have medical benefits for *some* women seeking abortion care, thus, there are circumstances under which these laws are valid. For example, Intervenors argue that, in some circumstances, it is medically necessary for patients to undergo procedures such as a physical examination, an ultrasound, or Rh testing. Intervenors' Proposed FOF, ¶ 145.

Whether Arizona follows *Salerno* in analyzing the constitutionality of abortion restrictions is an issue of first impression. Tellingly, the United States Supreme Court has struck down abortion regulations on a facial challenge, without applying *Salerno's* "no set of circumstances" test. *Stenberg v. Carhart,* 120 U.S. 914 (2000) (finding unconstitutional Nebraska's ban on partial-birth abortions). Following *Carhart,* the Court recognized abortion laws are an exception to the "no set of circumstances" test. *Sabri v. United States,* 541 U.S. 600, 609 (2004).

Arizona should, likewise, find abortion laws exempt from the *Salerno* standard. Arizona voters enshrined abortion as a "fundamental right" in the State Constitution. Ariz. Const. art. II, § 8.1(A). When analyzing whether a law violates a fundamental right, the presumption of constitutionality falls away. Instead of presuming the validity of the challenged law, a law infringing on a fundamental right is presumed to be invalid. *Gallardo v. State,* 236 Ariz. 84, 87-88 ¶ 9 (2014). It is illogical to presume that a law is invalid, while requiring the challenger (Plaintiffs) to show that there is "no set of circumstances" under which the law is valid. Perhaps for this reason, the Arizona Supreme Court has relaxed the *Salerno* standard in analyzing the constitutionality of other laws impacting a fundamental right, such as freedom of speech. *AZ Petition Partners LLC v. Thompson,* 255 Ariz. 254, 258 ¶ 18 (2023).

Further, Intervenors misconstrue the "no set of circumstances test". A facial challenge does not fail merely because there may be a situation where the challenged law could apply without violating a person's constitutional rights. *Simpson v. Miller*, 241 Ariz. 341, 349 (2017). *Simpson* addressed a facial challenge to a law which forbade bail to defendants accused of sexual conduct with a minor under age fifteen when the proof is evident or presumption great that the defendant committed the crime. The Court held that the law violated due process by categorically denying bail for crimes that do not inherently predict future dangerousness. *Id.* at ¶ 30. The Court rejected the State's *Salerno* argument:

The State urges that we should not hold the challenged provisions unconstitutional on their face because they may not be unconstitutional in all instances. [citing *Salerno*]. The State, however, is confusing the constitutionality of detention in specific cases with the requirement that it be imposed *in all cases*.

Id. at ¶ 31 (emphasis added).

The same reasoning applies here. That some women seeking an abortion may benefit from an ultrasound or Rh testing does not mean that the State may impose these tests "in all cases." This is true for all the Challenged Laws. Each of these laws apply across the board regardless of whether they "improve or maintain the health" of a woman seeking an abortion. Each of these laws infringe on a woman's "autonomous decision making" by mandating medical procedures and disclosure of information regardless of the patient's needs and wishes.

In sum, it is the Challenged Laws' universal suppression of medical judgment and choice that renders them invalid in all circumstances.

DISPOSITION

IT IS ORDERED:

1. Declaring that the following statutes (including subparts thereto) and regulations violate Arizona's Constitution, as applied to pre-viability abortions and abortion care: A.R.S. §§ 13-3603.02, 36-2157, 36-2158(A)(2)(d), and 36-2161(A)(25); A.R.S. §§ 36-2153(A), (F), 36-2158(A), 36-2156(A), 36-2162.01, 36-449.03(D)(3)(c), (G)(5), and A.A.C. R9-10-1509(A)(3)(b), (A)(4), (B), (E)(1); and A.R.S. §§ 36-2153(A), 36-2156(A), 36-2158(A), 36-3604, 36-2160(B), 36-449.03(D), and A.A.C. R9-10-1501(8), R9-10-1509(A)-(E)(1).
2. Permanently enjoining the State from implementing and enforcing the following statutes (including subparts thereto) and regulations, as applied to pre-viability

abortions and abortion care: A.R.S. §§ 13-3603.02(A)-(C) and (E)-(G), 36-2157, 36-2158(A)(2)(d), and 36-2161(A)(25); A.R.S. §§ 36-2153(A), (F), 36-2158(A), 36-2156(A), 36-2162.01, 36-449.03(D)(3)(c), (G)(5), and A.A.C. R9-10-1509(A)(3)(b), (A)(4), (B), (E)(1); and A.R.S. §§ 36-2153(A), 36-2156(A), 36-2158(A), 36-3604, 36-2160(B), 36-449.03(D), and A.A.C. R9-10-1501(8), R9-10-1509(A)-(E)(1).

3. No further matters remain pending and judgment is entered under Arizona Rule of Civil Procedure 54(c).

4. Plaintiffs shall file a verified statement of taxable fees and a motion for award of attorney fees (if sought) by **February 21, 2026**.

DATED this 2nd day of February, 2026.

/s/ HONORABLE GREGORY S. COMO

HONORABLE GREGORY S. COMO
JUDICIAL OFFICER OF THE SUPERIOR COURT