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CLERK OF THE JOHNSON COUNTY DISTRICT COURT
CASE NUMBER: 23CV03140
PII COMPLIANT

IN THE DISTRICT COURT OF JOHNSON COUNTY, KANSAS
CIVIL COURT DEPARTMENT

HODES & NAUSER MDS PA, et al.,

Plaintiffs

v.

Case No.: 23CV03140
Division 12

KRIS KOBACH, et al.

Defendants.

JOURNAL ENTRY OF JUDGMENT FOLLOWING TRIAL TO THE COURT

I. Introduction and Summary of Ruling

As the Court noted in its prior order granting a temporary injunction in this matter, the issue of abortion and a woman's right to make autonomous decisions on pregnancy has remained a "hot-button" social and political issue for decades in the United States, and the dispute currently before the Court reflects that ongoing tension between governmental policy mandates and the individual rights of Kansans and those within its borders. However, the issues presented and adjudicated herein are separate and distinct from any political or philosophical speech, discussion, or debate—as they should be—given the role of the judiciary as a co-equal but non-partisan branch of our tripartite system of government. Thus, the Court has applied relevant and binding law in Kansas to the factual record and the claims presented by the parties to this dispute, in order to reach its decision.

The instant case involves the evaluation of whether certain State abortion laws are: 1) valid and constitutional exercises of the State's authority to oversee the health

care profession and to protect women and/or potential future life; or 2) unconstitutional efforts by the government to inject itself into the physician-patient relationship in a singular and discrete set of circumstances, which infringes on the natural and fundamental rights of Kansas citizens and other women that are protected under our state Constitution.

Because a woman's right to bodily autonomy (including her right to decide whether to terminate or to continue a pregnancy) is fundamental, the Court concludes, given the overwhelming evidence adduced at trial, that the State's rationale and legislative schemes, whether the Women's Right to Know Act ("WRTKA"), its more-recent amendments of 2023 involving Abortion Pill Reversal theory (H.B. 2264 or "APR Mandate"), or H.B. 2749 (the "Reason Mandate"),[1] simply do not, in significant part, survive constitutional scrutiny under Section 1 of the Kansas Constitution Bill of Rights, as it relates to plaintiffs' patients.

Similarly, the intimate and intensely-personal nature of the physician-patient relationship and the concept of truly "informed consent" both necessarily require physicians to exercise professional judgment and discretion, in light of the particular needs of each pregnant patient, as to whether to "speak" or "not speak" the State-sponsored mandated information. As such, the Court further concludes that the Subject Laws also violate the fundamental rights to "free speech" held by the Provider plaintiffs

[1] For purposes of clarity, simplicity, and ease of reading, the Court will, where appropriate, refer to these various legislative mandates as the "Subject Laws." Where reference to only a particular statute is necessary, it will be separately identified as described above.

themselves (and others similarly situated), as bestowed by Section 11 of the Kansas Constitution Bill of Rights.

Plaintiffs have clearly and unquestionably demonstrated the merits of their claims based upon Sections 1 and 11 of the Bill of Rights, and thus, they are entitled to a permanent injunction as to Subject Laws, as further detailed below.

The Kansas Supreme Court has previously noted that trial courts face a "heavy task" when wrestling with these issues. Now, following a lengthy trial, encompassing thousands of pages of testimony and admitted documentary evidence, and upon thoughtful reflection, this Court again concurs with the observation that no easy answers exist for the existential questions raised by one of the most divisive social issues of our modern history. See *Hodes & Nauser MD's, P.A. v. Schmidt*, 309 Kan. 610, 681, 440 P.3d 461 (Kan. 2019) (hereinafter *Hodes I*). Nevertheless, towards that end and as it is duty bound to act, this Court has impartially and dispassionately evaluated both: 1) the legitimacy and propriety of the Subject Laws, from a state constitutional standpoint, and 2) the Subject Laws' demonstrated impacts on both plaintiffs and on pregnant women in Kansas. It has done so with an attitude of "active and critical analysis," as part of the requisite "searching judicial inquiry" required by Kansas law. *Id.* at 682 (citations omitted).

Invariably, some will likely disagree or take issue with the Court's ultimate conclusions and findings, whether based upon specific moral, ethical, or spiritual concerns. However, such considerations are (and must be) separate and apart from this Court's role in evaluating the potential constitutional encroachments of the State's efforts to impose its authority under the auspices of "police power," given our state

founders' emphasis on (and the primacy of) the people's inalienable natural rights. Those constitutional guarantees include the people's rights to make their own decisions regarding their bodies, health, family formation, and family life-decisions that can include whether to continue a pregnancy—all of which are necessary corollaries to the right of bodily autonomy. See Kansas Constitution, Bill of Rights Section 1.

Similarly, the right to freedom of speech, whether to speak or to avoid compelled speech and remain silent on an issue, is also a fundamental right that our state founders held dear and, thus, was enshrined in the Kansas Constitution's Bill of Rights. See Kansas Constitution, Bill of Rights Section 11.

In light of these specific fundamental rights and given the evidence adduced at trial, Kansas law sets a high bar for the Legislative branch to justify such regulatory mandates, and the prevailing law requires protection and analysis using a "strict scrutiny" standard. In the final analysis, the State Defendants simply failed in their obligation to clear that high bar to justify such intrusive legislative mandates. It is not, in this Court's view, even a close call, based upon the record before the Court.

Accordingly, in light of the Court's findings, analysis, and conclusions, as further detailed below, the Court hereby **GRANTS** plaintiffs' request for permanent injunctive relief, **IN PART**, and hereby permanently enjoins the State Defendants from enforcing, in any way, K.S.A. 65-6709, portions of K.S.A. 65-6710 (namely (a)(3), and (a)(4)), K.S.A. 65-6712, and H.B. 2264 (now codified at K.S.A. 65-6716), and H.B. 2749 (now as-revised K.S.A. 65-445). The Subject Laws violate the constitutional rights of both plaintiffs and their current and future patients, which are guaranteed by Section 1 and Section 11 of the Kansas Constitution's Bill of Rights. Similarly, the Subject Laws

further violate the rights of plaintiffs and their patients to equal protection under law, as prescribed by Section 2 of the Kansas Constitution's Bill of Rights. This is because the Subject Laws infringe upon their fundamental rights. Given the required level of legal/constitutional scrutiny under Kansas law, the State Defendants have failed to meet their burden of demonstrating narrow tailoring to effectuate a compelling governmental interest. Therefore, those portions of the Subject Laws must be enjoined permanently, in accordance with established Kansas law, pursuant to *Hodes I* and its progeny.

The Court further concludes that the APR Mandate is not void for vagueness, given prevailing law, and the plaintiffs' have failed to satisfy their own burden with respect to that claim. Nonetheless, that failure does not alter the Court's overall conclusions or relief, given that the APR Mandate, as a supplement to the WRTKA, unconstitutionally infringes upon the fundamental rights of plaintiffs and their patients. Those portions of the APR Mandate to which plaintiffs point as unconstitutionally vague are amongst those that are otherwise unconstitutionally infirm under Sections 1 and 11. Consequently, the APR Mandate must be enjoined, along with portions of the WRTKA, because of the plaintiffs' alternative theories—not because they are void for vagueness.

However, the Court further concludes that those invalid portions of the WRTKA and the Reason Mandate are severable, and thus, certain remaining portions of the Subject Laws may survive and continue in effect—as described below. Specifically, the Court concludes that portions of K.S.A. 65-6710 survive and can be implemented. See Discussion Section IV.G., infra pp. 242-51. Similarly, those portions of K.S.A. 65-445, which were in effect prior to the passage of the Reason Mandate, survive and can be implemented and enforced. *Id.*

II. Summary of Procedural Posture

During the Spring legislative session of 2023, the Kansas Legislature passed H.B. 2764, the APR Mandate. Following a legislative override of a gubernatorial veto of the legislation, that amendment was scheduled to become law, effective July 1, 2023. This case was thereafter filed on June 6, 2023, seeking various forms of declaratory and injunctive relief based upon plaintiffs' claims that the Women's Right to Know Act (WRTKA), including the new APR Mandate, violated the fundamental and natural rights of plaintiffs and their current and future patients. See Petition, Index No. 1.

Subsequent to extensive briefing by the parties, the Court conducted, on August 8, 2023, a hearing on the plaintiffs' request for a temporary injunction.[2] Thereafter on October 30, 2023, the Court issued it Journal Entry granting a temporary injunction as to the WRTKA, including the APR Mandate. See Journal Entry, Index No. 85. In doing so, the Court concluded that the plaintiffs were likely to succeed on the merits of their claims, with respect to the WRTKA, because the statutory scheme, including the new APR Mandate, likely violated the constitutional rights of plaintiffs and their patients, which are guaranteed by the Kansas Constitution's Bill of Rights. See *Id.* In particular, the Court concluded that the WRTKA likely violated the fundamental and natural rights of pregnant women to exercise their bodily autonomy (Kansas Constitution Bill of Rights Section 1), including the right to make decisions regarding termination of pregnancy prior to 22 weeks after the last menstrual period ("LMP"). *Id.* The Court further concluded that the statutory scheme likely violated the Provider plaintiffs' corresponding

[2] The parties had already agreed to a stay the effect of the APR Amendments, pending the Court's final adjudication of the merits. See Index No. 32, 38.

fundamental rights to free speech guaranteed by Section 11 of the Kansas Constitution's Bill of Rights. Accordingly, the Court temporarily enjoined relevant portions of the WRTKA, including the new APR Mandate, pending a final trial to the Court on the asserted claims and issues.[3] *Id.*

On April 24, 2024, the Kansas Legislature passed, over gubernatorial veto, H.B. 2749 (the "Reason Mandate"), which added requirements on plaintiffs, as abortion providers, to discuss with and inquire of their patients as to certain topics, including *but not limited to* what the "most important reason" was/is underlying their desire to terminate their pregnancy. That law was scheduled to become effective on July 1, 2024. In response, the plaintiffs sought leave to amend their operative pleading to include constitutional challenges to H.B. 2749 largely identical to those already pending as to the WRTKA. See Index No. 115. That request to add supplemental claims relating to H.B. 2749 was granted by the Court on July 1, 2024, as there were common questions of law and/or fact presented by the claims, which were part of related occurrences, and as the consolidation of all such claims would promote judicial economy and efficiency, consistent with the Rules of Civil Procedure and the liberal standard applicable to evaluating such requests. The Court's written Journal Entry on the issue was filed on July 22, 2024. See Index No. 130.

Following the conclusion of pretrial discovery and the completion of a final pretrial conference, in accordance with K.S.A. 60-216 and Rule 140, the Court conducted a bench trial of the claims, beginning on September 26, 2025, and continuing on

[3] The parties subsequently agreed and stipulated that the State Defendants would not seek to enforce the WRTKA, until such time as the Court rendered its final judgment in this action. See Joint Stipulation, Index No. 99.

September 29, 30, October 14, 15, 16, and 17. The Court took the matter under advisement for further consideration and formal ruling, following the submission by the parties of potential minor additions to the evidentiary record and of proposed findings of fact and conclusions of law. The parties finally submitted those additional items in December of 2025, which rendered the case ready for review and consideration.

III. Findings of Fact

The Court makes the following specific factual findings, based upon the record, all of which are material to the Court's analysis and rulings herein. References to the record within these findings are intended to be illustrative, not exhaustive. Similarly, the references to specific findings within the later Analysis portion of the Court's ruling are also intended to be non-exhaustive support, as all of these factual findings are material.

The Issues at Stake.

1. Pregnancy is an intimate healthcare condition; for some, it is joyous. For others, it is not. Trial Tr. vol. I (PM), 40:4-10 (Nauser); see also FOF ¶2.

2. The decision to terminate a pregnancy is complex and intensely personal. Trial Tr. vol. I (PM), 101:16-23 (Alsaden); Trial Tr. vol. III (AM), 130:24-131:5, 131:18-25 (Kimport). Some abortion patients have a health condition that complicates their pregnancy or seek abortion because the fetus has been diagnosed with a severe or lethal anomaly. Pretrial Order, Index 630; at 9 (Pl. Fact 3). Some abortion patients simply "didn't want to be pregnant," Trial Tr. vol. I (AM), 78:15-18 (Nauser), while others have terminated "a pregnancy that was very desired, and they have found out there's something wrong with the fetus or for the pregnancy itself." *Id.* at 88:20-22 (Nauser).

3. The Kansas Constitution protects a woman's fundamental right to bodily autonomy, which includes the decision to end a pregnancy (the right to abortion). Hodes

& Nauser v. Schmidt (Hodes I), 309 Kan. 610, 440 P.3d 461 (2019); see also Trial Tr. vol. I (PM), 46:24-47:7 (Nauser).

4. That right to bodily autonomy was re-affirmed in two related decisions issued by the Kansas Supreme Court in 2024. See *Hodes & Nauser, MDs, P.A. v. Stanek*; 318 Kan. 995 (2024) ("Hodes II"); *Hodes & Nauser, MDs, P.A. v. Kobach*, 318 Kan. 940 (2024) ("Hodes III").

Kansas Legal Landscape Governing Abortion.

5. The common law doctrine of informed consent imposes on physicians a legal duty to disclose the medically material risks, benefits, and alternatives of an intervention, as well as the consequences of no intervention, to obtain the patient's consent to the proposed intervention. Trial Tr. vol. II (PM), 57:25-58:15, 59:9-61:15 (Sawicki); see *id.* at 66:12-21, 68:10-21, 69:21-70:6 (Sawicki) (courts have rejected attempts to expand the duty of disclosure). The common law duty to obtain informed consent prior to treatment developed in response to medical paternalism, to protect patients' autonomy. *Id.* at 55:10-13 (Sawicki).

6. The Kansas Board of Healing Arts ("BOHA") is the regulatory body responsible for enforcing the Healing Arts Act, which prohibits licensees in the healing arts from engaging in unprofessional conduct, including "[a]ssisting in the care or treatment of a patient without" the patient's consent. K.S.A. 65-2837(b); see also Trial Tr. vol. I (AM), 21:13-15, 30:14-19 (Nauser). The BOHA has a robust and active investigative and enforcement process to oversee licensees subject to its jurisdiction. See Plaintiffs' Exhibit 15, pp. 5-6.

7. Violations of the duty to obtain informed consent also expose licensees to potential malpractice liability. See, *e.g.*, Trial Tr. vol. I (AM), 28:19-24 (Nauser).

8. The State of Kansas has long attempted to regulate women's reproductive choices. Through sterilization, institutionalization, and selective prosecution, the State historically displaced women as the decision-maker about matters of sex and reproduction, and punished women who did not conform to its chaste-until-marriage vision of womanhood. Trial Tr. vol. IV (PM), 67:23-69:6, 81:2-82:18 (Syrett). Its efforts to criminalize abortion also reflect a history of using the law to enforce harmful sex stereotypes about women and their role in society. In the late 19th century, proponents of abortion criminalization considered the fact that single women sought abortions as evidence of a "breakdown in sexual morality." *Id.* at 65:1-14, 71:10-14 (Syrett). They viewed married women as selfish and frivolous for obtaining abortion and urged that women's "homes should be [their] towers and castles of strength" and their "children be [their] jewels." Pls.' Ex. 146, at 229 ("Androgynism," Leavenworth Medical Herald (1867)); Trial Tr. vol. IV (PM), 65:15-21, 71:10-14 (Syrett); see also Pls.' Ex. 147, at 359 ("Morality: From a Medical Standpoint," Transactions of the State Medical Society of Kansas (1882)).

9. Kansas maintains statutory cutoffs and criteria for abortion. Termination of a pregnancy is permitted prior to viability and so long as it occurs prior to 22 weeks LMP, except in rare exceptional/emergent circumstances. See K.S.A. 65-6703; K.S.A. 65-6724.

1997 Enactment

10. The Women's Right to Know Act ("WRTKA") was enacted in 1997 and later amended six times. Pretrial Order, Index No. 630; pg. 9 (Def. Fact 2). The Court takes judicial notice of the Subject Laws and the legislative changes and iterations of the WRTKA since its original enactment.

11. The original 1997 enactment provided that "voluntary and informed consent" existed only if, at least 24 hours in advance of an abortion, "the physician who is to perform the abortion or the referring physician" has, in writing, informed the woman:

a. the name of the physician who will perform the abortion;

b. a description of the proposed abortion method;

c. a description of risks related to the proposed abortion method, including risks to the woman's reproductive health and alternatives to the abortion that a reasonable patient would consider material to the decision of whether or not to undergo the abortion;

d. the probable gestational age of the fetus at the time the abortion is to be performed, along with a detailed statement of Kansas law regarding abortions post "viability";

e. the probable anatomical and physiological characteristics of the fetus at the time the abortion is to be performed;

f. the medical risks associated with carrying a fetus to term; and

g. any need for anti-Rh immune globulin therapy, if she is Rh negative, the likely consequences of refusing such therapy and the cost of the therapy.

12. At that time, the WRTKA further required additional written notification to the patient, which was required to be provided by "the physician who is to perform the abortion, the referring physician or a qualified person." Those additional notifications included that:

a. medical assistance benefits may be available for prenatal care, childbirth and neonatal care, and that more detailed information on the availability of such assistance is contained in the printed materials given to her and described in K.S.A. 65–6710,[4] and amendments thereto;

b. the printed materials in K.S.A. 65-6710, and amendments thereto, describe the fetus and list agencies which offer alternatives to abortion with a special section listing adoption services;

c. the father of the fetus is liable to assist in the support of her child, even in instances where he has offered to pay for the abortion except that in the case of rape this information may be omitted; and

d. the woman is free to withhold or withdraw her consent to the abortion at any time prior to invasion of the uterus without affecting her right to future care or treatment and without the loss of any state or federally-funded benefits to which she might otherwise be entitled.

13. Thus, the statutory scheme, in practical effect, imposed at least a 24-hour minimum waiting period prior to obtaining the desired medical procedure, regardless of the patient's history, medical status, or status of her existing decision-making process (whether complete and voluntary or still contemplated).

14. In addition, prior to the procedure, preparation for the procedure, or administration of any medication for the procedure, the physician that was to perform the procedure (and his/her staff) was statutorily mandated to meet privately with the patient to ensure that she has an adequate opportunity to ask questions of the physician concerning the abortion. Any questions were to be answered by the physician in the patient's "own language." Thereafter, the woman was required to fill out and sign a written certification that she has been provided all of the materials, information, and

[4] The statute required physicians to provide the printed materials described in K.S.A. 65-6710 to each patient seeking abortion care at least 24 hours prior to an abortion.

consultations required therein, which the physician performing the procedure (or an agent) then receives and maintains the certification.

15. Finally, the provisions (K.S.A. 65-6710) also required the Kansas Department of Health and Environment ("KDHE") to publish and widely distribute (with annual updates) information and written materials identifying "public and private agencies and services available" as an alternative to obtaining an abortion (adoption services, aid agencies, prenatal care), along with information that the biological father of a child, once born, has legal support obligations. The published information also was to include the following statement, as part of the written materials KDHE maintained and that physicians were obligated to provide in writing prior to the 24-hour waiting period:

> "Many public and private agencies exist to provide counseling and information on available services. You are strongly urged to seek their assistance to obtain guidance during your pregnancy. In addition, you are encouraged to seek information on abortion services, alternatives to abortion, including adoption, and resources available to post-partum mothers. The law requires that your physician or the physician's agent provide the enclosed information."

16. KDHE was further required to create and make available materials on the probable anatomical and physiological characteristics of the fetus at various times throughout a normal pregnancy at every two-week milestone. The information was required to be "objective, nonjudgmental and designed to convey only accurate scientific information about the fetus." No specific size, font, or color requirements were imposed in the 1997 version of the Act; however, the information was required to be in typeface "large enough to be clearly legible" and made available in both Spanish and English.

The 2009 Amendments.

17. In 2009, S.B. 238 was passed, which amended the Act to change various requirements, including, in relevant part:

a. Limiting the circumstances that qualify as a "medical emergency," which, if present, avoids myriad requirements under the scheme;

b. Adding required written information be provided prior to the 24-hour waiting period to include the contact information for free counseling relating to "medically challenging pregnancies"[5] and for free perinatal hospice services;

c. Obligating KDHE to also post its information online on its governmental website;

d. Adding a second waiting period of 30 minutes after the in-person "question and answer" session between the patient and her physician;

e. Adding the obligation of physicians using ultrasound equipment in preparation for or during an abortion procedure to:

   i. Inform the patient that she has the right to view the ultrasound image of her fetus at no cost and make the offer to view;

   ii. Inform the patient that she has the right to receive a copy of the ultrasound image of her fetus at no cost and make the offer to provide a copy; and

   iii. Certify in writing (with a time stamp denoting these discussions) that these requirements have been met, along with a signed affirmation by the patient that she has accepted or rejected these options;

f. Adding the obligation of physicians using heart-monitoring equipment in preparation for or during an abortion procedure to:

   i. Inform the patient that she has the right to hear the heartbeat of her fetus at no cost and makes the offer to listen;

   ii. Certify in writing (with a time stamp denoting these discussions) that these requirements have been met, along with a signed affirmation by the patient that she has accepted or rejected these options;

[5] A "medically challenging pregnancy" was defined as "a pregnancy where the fetus is diagnosed as having: (1) A severe anomaly; or (2) an illness, disease or defect which is invariably fatal."

The 2011 Amendments.

18. In 2011, H.B. 2035 was passed, which modified the Act's provisions to include the following, in part:

a. Adding specific information to the statements that must be provided in writing prior to the mandatory 24-hour waiting period, regarding the "risk of premature birth in future pregnancies" (after an abortion procedure) and the "risk of breast cancer" (after an abortion procedure)";

b. Adding a requirement to provide patients "a listing of websites for national perinatal assistance," including those that provide the services for free;

c. Adding to the information that must be provided in writing prior to the mandatory 24-hour waiting period, that:

> "by no later than 20 weeks from fertilization, the unborn child has the physical structures necessary to experience pain. There is evidence that by 20 weeks from fertilization unborn children seek to evade certain stimuli in a manner that in an infant or an adult would be interpreted to be a response to pain. Anesthesia is routinely administered to unborn children who are 20 weeks from fertilization or older who undergo prenatal surgery";

d. Adding a requirement that the conspicuously-posted sign for patients also include the internet address for the KDHE website, from which additional pregnancy resources may be obtained, along with further mandatory statements on the sign. Specifically, it added the following mandatory language:

> "It is unlawful for anyone to make you have an abortion against your will, even if you are a minor. The father of your child must provide support for the child, even if he has offered to pay for an abortion. If you decide not to have an abortion, you may qualify for financial help for pregnancy, childbirth and newborn care. If you qualify, Medicaid will pay or help pay the cost of doctor, clinic, hospital and other related medical expenses, including childbirth delivery services and care for your newborn baby. Many agencies are willing to provide assistance so that you may carry your child to term, and to assist you after your child's birth";

e. Requiring each office or clinic at which abortion services are provided that maintains a public website to link, on its homepage, to the KDHE's website, along with the following message:

> "The Kansas Department of Health and Environment maintains a website containing ***objective, nonjudgmental, scientifically accurate information*** about the development of the unborn child, as well as video of sonogram images of the unborn child at various stages of development. The Kansas Department of Health and Environment's website can be reached by clicking here." (emphasis added).

f. Adding requirements that KDHE include in the printed/website materials, which are also required to be handed out by each physician, the following statements:

> "(A) That by no later than 20 weeks from fertilization, the unborn child has the physical structures necessary to experience pain; (B) that there is evidence that by 20 weeks from fertilization unborn children seek to evade certain stimuli in a manner that in an infant or an adult would be interpreted to be a response to pain; (C) that anesthesia is routinely administered to unborn children who are 20 weeks from fertilization or older who undergo prenatal surgery; (D) that less than 5% of all natural pregnancies end in spontaneous miscarriage after detection of cardiac activity, and a fetal heartbeat is, therefore, a key medical indicator that an unborn child is likely to achieve the capacity for live birth; and (E) that abortion terminates the life of a whole, separate, unique, living human being";

g. Specifying, in detail, exactly what language/message that KDHE is required to disclose, including about: the various time periods during a woman's pregnancy, along with reiteration of Kansas law's requirements and restrictions relating to an abortion; information about adoption, information about child support; and information about parentage actions.

h. Deleting language from K.S.A. 65-6710(a) that addressed consideration of "abortion services", such that the State-mandated materials only "encouraged" pregnant women to "seek information on alternatives to abortion, including adoption, and resources available to postpartum mothers." The written materials still, however, required these amended materials to state: "The law requires that your physician or the physician's agent provide the enclosed information."

The 2014 Amendments.

19. In 2014, S.B. 54 passed, which amended the Act in the following manner:

    a. Modified the language of K.S.A.65-6709 by **deleting** the statute's mandatory representation and requirement that the KDHE provide, on its website, ***"objective, nonjudgmental, scientifically accurate"*** information pertaining to pregnancy and the fetus's development. The updated language required providers to maintain the link on its website homepage to the KDHE's site; however, the amended version provided that a "website containing information" exists and could be reached by "clicking" the link on the physician/clinic/offices page.

The 2017 Amendments.

20. In 2017, S.B. 83 was enacted, which amended the Act (and specifically K.S.A. 65-6709) as follows:

    a. Specifying that the written messaging that physician providers were required to provide prior to the 24-hour waiting period, do so on "white paper in a printed format in black ink with 12-point Times New Roman font";

    b. Adding the obligation to provide the following additional information on the specific physician performing the procedure, prior to the inception of the 24-hour waiting period:

        i. the name of such physician;

        ii. the year in which such physician received a medical doctor's degree;

        iii. the date on which such physician's employment commenced at the facility where the abortion is to be performed;

        iv. whether any disciplinary action has been taken against such physician by the state board of healing arts by marking either a box indicating "yes" or a box indicating "no" and if the box indicating "yes" is marked, then provide the website addresses to the board documentation for each disciplinary action;

        v. whether such physician has malpractice insurance by marking either a box indicating "yes" or a box indicating "no";

        vi. whether such physician has clinical privileges at any hospital located within 30 miles of the facility where the abortion is to be performed by marking either a box indicating "yes" or a box indicating "no" and if the

box indicating “yes” is marked, then provide the name of each such hospital and the date such privileges were issued;

vii. the name of any hospital where such physician has lost clinical privileges; and

viii. whether such physician is a resident of this state by marking either a box indicating “yes” or a box indicating “no”.

Practical Effect of WRTKA Amendments.

21. Though healthcare providers already have an ethical and legal duty to obtain informed consent prior to providing any treatment, the WRTKA (as well as the Reason Mandate) singles out abortion for imposition of a web of additional requirements that must be met before an abortion may be provided. See Trial Tr. vol. II (PM), 53:3-10, 53:20-54:5 (Sawicki) (WRTKA “is unusual because it focuses only on one narrow area of medical practice and also provides very specific and detailed requirements as to what doctors have to communicate”).

22. The WRTKA is a purported effort to specifically define the explicit contours of the informed-consent process for every abortion in Kansas. It requires providers to convey state-mandated disclosures—in part using state-scripted language—only to patients seeking abortion, and the law deems their consent “voluntary and informed,” ***only*** if they certify compliance with a host of waiting periods and other logistical requirements. See K.S.A. 65-6708-6716. Thus, to obtain an abortion, patients must certify in writing that they received the required materials and offers at the specified times. K.S.A. 65-6709(e), (j).

23. The WRTKA requires Plaintiffs to convey to patients, at least 24 hours before an abortion, a series of state-mandated disclosures, many of which must be “on white paper in a printed format in black ink with 12-point times new roman font,” along

with materials published by KDHE. See K.S.A. 65-6709(a)-(b), (d). 9-26 AM Trial Tr. Vol I (AM), 121: 4-16) (Nauser) (WRTKA requires seven different signs posted throughout the clinic).

24. The state-mandated disclosures contain, among others, detailed "information concerning the physician who will perform the abortion," including "whether such physician has clinical privileges at any hospital located within 30 miles of the facility where the abortion is to be performed" and "whether such physician is a resident of this state"; "a description of the risks of the proposed abortion method, including risk of premature birth in future pregnancies, risk of breast cancer and risks to the woman's reproductive health"; that "medical assistance benefits may be available for prenatal care, childbirth and neonatal care," the child support liability of "the father of the unborn child," that "the abortion will terminate the life of a whole, separate, unique, living human being"; and that "the unborn child has the physical structures necessary to experience pain" by "no later than" 22 weeks as dated from the LMP. K.S.A. 65-6709.

25. The KDHE-published materials, which the WRTKA requires physicians to provide patients at least 24 hours prior to an abortion, replicate many of the state-mandated disclosures and include additional state-scripted messages, such as "encourage[ment] to seek information on alternatives to abortion, including adoption, and resources available to postpartum mothers," as well as text describing and pictures representing "the development of an unborn child at two-week gestational increments from fertilization to full term." K.S.A. 65-6710(a). In fact, these written disclosures that must be distributed by physicians to patients, in advance, state:

> Many public and private agencies exist to provide counseling and information on available services. You are strongly urged to seek assistance from such agencies in order to obtain guidance during your pregnancy. **In addition, you are encouraged to seek information on alternatives to abortion, including adoption, and resources available to postpartum mothers. The law requires that your physician, or the physician's agent, provide this information.**

Id. (emphasis added).

26. In addition to mandating a 24-hour waiting period after provision of various mandated disclosures "in writing," the WRTKA mandates another 30-minute waiting period after the patient "meet[s] privately with the physician who is to perform the abortion." K.S.A. 65-6709(a), (c).

27. If a physician uses ultrasound equipment or heart-monitoring equipment in connection with an abortion, the patient must be offered an opportunity to view and keep the ultrasound image at least 30 minutes before the abortion, and the provider must create and maintain certification, in writing, of the 30-minute delay and of compliance, along with signatures for both the provider and patient. K.S.A. 65-6709(h).

28. The WRTKA also requires Plaintiffs to post "huge" (roughly two feet by four feet, depending on the signage) signs with state-scripted text, some of which replicates information included in the state-mandated disclosures, in at least ¾ inch, boldface type, and to publish on the homepages of their websites a state-scripted link to KDHE's website for the materials published pursuant to the Act. K.S.A. 65-6709(b), (d), (k), (l); see also Trial Tr. Vol I (AM), 126: 2-8)(Nauser); Trial Tr. Vol II (PM), 123:22 to 125:10 (Wales).

29. Failure to comply with the WRTKA is punishable as "unprofessional conduct," which may subject physicians to criminal, administrative, and/or disciplinary consequences up to and including loss of licensure. K.S.A. 65-6712, 65-2836, 65-2862.

30. On June 24, 2022, the U.S. Supreme Court overturned *Roe v. Wade*, rescinding the federal constitutional right to abortion, as clarified by *Casey v. Planned Parenthood* in 1992, that had been the law of the land for nearly 50 years. *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 142 S.Ct. 2228, 213 L.Ed.2d 545 (2022); Trial Tr. vol. II (PM), 115:8-15 (Wales). Six weeks later, Kansans rejected a legislatively referred constitutional amendment that would have declared that the Kansas Constitution does not guarantee a right to abortion. Kan. Sec. of State, 2022 Primary Election Official Vote Totals (2022) (Constitutional Amendment "No" vote passed with 59.16% of the vote); Trial Tr. vol. I (AM), 124:6-7) (Nauser); Trial Tr. vol I (PM), 47:4-7 (Nauser); Trial Tr. vol. III (AM), 111:15-17 (Wales).

The 2023 Amendments to the WRTKA—The APR Mandate.

31. In April of 2023, the Legislature overrode a gubernatorial veto to enact the APR Mandate, the sixth, and, prior to trial, the most recent, amendment to the WRTKA. H.B. 2264. KS LEGIS 88 (2023), 2023 Kansas Laws Ch. 88 (H.B. 2264); see K.S.A. 65-6716 (2024).

32. The APR Mandate requires providers to distribute the State's message that it "may be possible to reverse the intended effect" of a medication abortion using mifepristone "if the woman changes her mind, but that time is of the essence," to direct patients to KDHE-published "information on reversing the effects of a medication abortion that uses mifepristone," and to advertise "other relevant telephone and internet

resources" that purport to provide "assistance to attempt to reverse the medication abortion." K.S.A. 65-6716(b)-(c).

33. That message must be distributed multiple times through multiple means, including orally, twice in writing, and on massive signs with lettering in at least ¾ inch, boldfaced type in every waiting room and patient consultation room used by patients seeking medication abortion. K.S.A. 65-6716(b)-(c); Trial Tr. Vol I (AM), 121: 4-16) (Nauser) (WRTKA requires seven different signs posted throughout the clinic).

34. The APR Mandate prohibits the provision of medication abortion until at least 24 hours after the patient has received the mandated disclosures regarding abortion APR both "in writing" and "either by telephone or in person," except in certain narrow circumstances defined as a medical emergency. K.S.A. 65-6716(c).

35. The APR Mandate requires KDHE to publish, in print and on the website required to be maintained under K.S.A. 65-6710, "comprehensible materials designed to inform women of the possibility of reversing the effects of medication abortion that uses mifepristone and information on resources available to reverse the effects of a medication abortion that uses mifepristone." K.S.A. 65-6716(e); see Pls.' Ex. 5a, at 18 (KDHE Woman's Right to Know Handbook).

36. The KDHE Handbook directs patients to a "24/7 Abortion Pill Reversal hotline," which appears to be part of the Abortion Pill Reversal Network run by Heartbeat International. Pls.' Ex. 5a, at 18 (KDHE Woman's Right to Know Handbook); see Trial Tr. vol. II (PM), 34:15-35:3 (Schreiber).

37. Though the APR Mandate states that the "website shall also include other relevant telephone and internet resources containing information on where the patient can obtain timely assistance to attempt to reverse the medication abortion," the KDHE Handbook does not yet contain any other telephone or internet resources. Pls.' Ex. 5a, at 18 (KDHE Woman's Right to Know Handbook).

38. In addition to the other enforcement mechanisms included in the WRTKA, the APR Mandate also creates a civil cause of action against non-compliant health-care providers for violations of its terms that may be enforced by a variety of individuals, other than the pregnant woman. Statutory plaintiffs may seek actual damages, exemplary/punitive damages, and attorney fees. These "bounty hunter" type provisions only permit preservation of the pregnant patient's anonymity in such litigation, if, inter alia, the court finds that it is "essential," and that no "reasonable less restrictive alternative" exists. K.S.A. 65-6716(h)-(i).

The Reason Mandate (H.B. 2279).

39. In April 2024, the Legislature again overrode a gubernatorial veto to enact the Reason Mandate, which amends K.S.A. 65-445. H.B. 2749; K.S.A. 65-445. KS LEGIS 89 (2024), 2024 Kansas Laws Ch. 89 (H.B. 2749).

40. Prior to the Reason Mandate, K.S.A. 65-445 required reports of induced terminations of pregnancy ("ITOP") to be submitted to KDHE on an annual basis but left "the information required in the reports" to the Secretary's discretion. H.B. 2749 § 1(i) (amending K.S.A. 65-445(i)). Pursuant to this authority, KDHE promulgated regulations requiring that ITOP reports include the patient's de-identified biographical data, certain

medical history, and certain information regarding the reported abortion. See K.A.R. 28-56-2(d); Pls.' Ex. 6a (Pre-H.B. 2749 ITOP Reporting Form).

41. The Reason Mandate codifies the information already sought on ITOP forms per KDHE regulations and adds new requirements that, for each abortion provided at a covered facility, the following information be reported: (1) "whether, in the 30 days prior to the abortion, the patient received services, financial assistance, excluding financial assistance in obtaining an abortion, or other assistance from a nonprofit organization that supports pregnant women"; (2) "whether the patient reported having experienced domestic violence in the 12 months prior to the abortion"; and (3) "whether the patient is living in a place that the patient considers to be safe, stable and affordable." H.B. 2749 § 1(e). There is no option to decline answering those questions. *Id.*

42. The Reason Mandate further requires that each abortion patient "be asked, prior to the termination of such patient's pregnancy," which of eleven state-scripted reasons was the "most important factor in such patient's decision to seek an abortion," including whether "the patient already has enough, or too many, children," "the patient's husband or partner wants such patient to have an abortion," or the pregnancy was a result of rape or incest. H.B. 2749 § 1(c). "If the patient declines to answer, such response shall be recorded." *Id.* The "number of times each of the reasons listed in subsection (c) was described as the most important" and "the number of times a patient seeking an abortion was asked about the reasons listed in subsection (c) and declined to answer" during the biannual reporting period must be reported to KDHE. *Id.* at § 1(d).

43. One proposed amendment that would have added “the patient wants to have an abortion,” to the Reason Mandate’s list of reasons was rejected. Pls.’ Ex. 9 (Miller Amendment to H.B. 2749)); Pls.’ Ex. 10 (House Journal, p. 1892 (Mar. 6, 2024)).

44. Another proposed amendment to the Reason Mandate would have required patients seeking vasectomies to be asked to select the “most important factor” in their decision to seek a vasectomy from an analogous list of government-scripted reasons was ruled not germane. Pls.’ Ex. 8 (Oropeza Amendment to H.B. 2749); Pls.’ Ex. 10 (House Journal, p. 1891 (Mar. 6, 2024)). As a result, the amendment failed and was not included in the enacted law.

45. Representative Brenda Landwehr (R-105), chairwoman of the Committee on Health and Human Services (which sponsored the bill), stated that the Reason Mandate’s motivation was to “[m]ake sure we’re making the right decision for these women” who are seeking abortions in Kansas. Pls.’ Ex. 11 (House Journal, p. 3420 (Apr. 29, 2024)).

46. KDHE—the agency responsible for collecting and/or utilizing the Reason Mandate data—was neither consulted nor involved in drafting the Reason Mandate. Pls.’ Ex. 18, at 5 (KDHE Resp. to Pls.’ 2d Set of Req. for Admis., RFA 19); Pls.’ Dep. Desigs. vol. 2, Ex. C, Lara (KDHE) Dep. 28:18-29:6 (May 19, 2025). It was not consulted regarding any existing problem or any language used in these provisions, and it has no plans for the use of any such data. See Pls.’ Ex. 18, at 5 (KDHE Resp. to Pls.’ 2d Set of Req. for Admis., RFA 19); Pls.’ Dep. Desigs. vol. 2, Ex. C, Lara (KDHE) Dep. 28:18-29:6 (May 19, 2025).

47. The Reason Mandate went into effect on July 1, 2024, but it has not been enforced, and no rulemaking required by H.B. 2749 has been instituted. Pretrial Order; Index No. 630; at 9 (Def. Fact 7). Nonetheless, by its terms, violations of the Mandate by a provider can result in civil, criminal, and/or administrative consequences. (K.S.A. 65-445(f)(2025)).

48. Kansas law does not condition patients' access to any other health service, including any other sexual or reproductive health service, upon compliance with such unique regulatory mandates heaped on top of generally applicable legal and ethical duties to obtain informed consent. Trial Tr. vol. I (AM), 30:20-24, 78:23-79:4, 85:22-86:4, 86:22-87:5, 91:23-92:2, 92:14-17, 94:9-12, 98:4-6, 101:19-102:2, 104:18-105:10, 106:12-19 (Nauser); Trial Tr. vol. I (PM), 95:21-97:9 (Alsaden); Trial Tr. vol. IV (AM), 24:9-16 (Ranney).

49. Additionally, Kansas does not condition access to any other healthcare service on being asked questions about the "most important factor" in their treatment decision or answering questions about sensitive, non-clinical information about whether the patient sought services or assistance from a non-profit, experienced and affirmatively reported domestic violence, or is living in a place that the patient considers safe, stable, and affordable. Trial Tr. vol. I (AM), 53:17-54:10, 55:11-13, 55:24-56:5, 57:18-24, 60:24-61:3 (Nauser); Trial Tr. vol. I (PM), 103:5-11 (Alsaden); Pls.' Ex. 17, at 15 (KDHE's R&Os to Pls.' 2d Set of ROGs, Rogs. 39-42); Pls.' Dep. Desigs. vol. 1, Ex. A, Ahmed (KDHE) Dep. 50:22-51:4 (May 19, 2025); *id.*, Ex. B, Dean-Campmire (KDHE) Dep. 29:12-30:13, 32:1-5; supra FOF ¶ 48; see Trial Tr. vol. III (PM), 61:16-62:22 (Lee) (the Reason Mandate does not collect the type of "observable events with observable

characteristics" typical of registration of vital events, including births and deaths); cf. Trial Tr. vol. V (PM), 59:18-61:4 (Wubbenhorst) (relying on ACOG Committee Opinion 554 and discussing coercion); Pls.' Ex. 205, at 1 (ACOG Committee Opinion 554) (suggesting that providers screen patients for reproductive and sexual coercion at visits like annual exams, new patient visits, and during obstetric care).

Litigation Posture and Parties.

50. The plaintiffs in this case are Traci Lynn Nauser, M.D., Hodes & Nauser, MDs, P.A., d/b/a Center for Women's Health ("CWH"), and Comprehensive Health of Planned Parenthood Great Plains ("Comprehensive Health" or "Planned Parenthood").

51. Plaintiff Traci Lynn Nauser, M.D., is a board-certified obstetrician-gynecologist licensed to practice medicine in Kansas. Trial Tr. vol. I (AM), 21:9-18 (Nauser). Dr. Nauser owns and operates Hodes & Nauser, MDs, P.A. Trial Tr. vol. I (AM), 18:5-6, 21:9-18 (Nauser).

52. For nearly three decades, Dr. Nauser has provided a full range of obstetrical and gynecological services, including family planning services, Pap smears, prenatal care, delivering babies, gynecological procedures and surgeries, screening for and treatment of sexually transmitted infections ("STIs"), screening for gynecological and breast cancers, treatment of menopausal symptoms, treatment of dysfunctional uterine bleeding and fibroids, infertility treatments, and abortions. Trial Tr. vol. I (AM), 18: 14-25, 19:1 (Nauser).

53. Plaintiff Hodes & Nauser, MDs, P.A., which also does business as Center for Women's Health ("CWH"), is a private medical practice in Overland Park, Kansas.

Trial Tr. vol. I (AM), 18:7-13 (Nauser). CWH provides a full range of obstetrical and gynecological services, including first period care, prenatal care, delivering babies, gynecological procedures and surgeries, treatment of menopausal symptoms, treatment of dysfunctional uterine bleeding and fibroids, miscarriage management, and abortions. Trial Tr. vol. I (AM), 18:7-21, 35:14-22, 40:10-16, 134:24-135:13 (Nauser).

54. Plaintiff Comprehensive Health of Planned Parenthood Great Plains ("Comprehensive Health") is a non-profit health care organization that operates four health care centers in Kansas, located in Overland Park, Wichita, Kansas City, and Pittsburg. Trial Tr. vol. II (PM), 116:9-19 (Wales); Trial Tr. vol. I (PM), 58:16-20, 60:10-19 (Alsaden). Comprehensive Health provides a range of family-planning services, including medication and procedural abortion services, contraceptive care, and STI testing. Trial Tr. vol. I (PM), 57:18-21, 58:16-20, 60:10-19 (Alsaden); Defs.' Ex. 77a (PP-0002091).

55. As licensees in the healing arts, Dr. Nauser and Comprehensive Health's physicians are regulated by BOHA. K.S.A. 65-2836, 65-2838, 65-2839a; Trial Tr. vol. I (AM), 21:13-15, 30:14-19 (Nauser); Trial Tr. vol. I (PM), 59:23-25 (Alsaden).

56. Plaintiffs provide two methods of abortion: medication abortion and procedural abortion. See Pretrial Order, Index No. 630; at 10 (Pl. Fact 12).

57. Plaintiffs provide medication abortion using a two-drug regimen: 200 mg of mifepristone, followed 24 to 48 hours later by 800 mcg of misoprostol. See Pretrial Order, Index No. 630; at 10 (Pl. Fact 15). These medications are also used to treat patients who have a miscarriage with retained tissue. *Id.* at 10 (Pl. Fact 21).

58. Because they offer abortion, Plaintiffs have been subject to, and complied with, the WRTKA and its amendments since each were enacted and until this Court entered a temporary injunction. Pretrial Order, Index No. 630; at 9 (Def. Fact 3-4).

59. In 2013, CWH and a predecessor to Comprehensive Health filed lawsuits challenging aspects of a previous version of the WRTKA. Trial Tr. vol. I (PM), 46:20-23 (Nauser); Trial Tr. vol. III (AM), 72:18-73:23 (Wales). Since 2013, the "world in which [Plaintiffs] operate[] . . . ha[s] changed dramatically," both factually in terms of patient demand and legally in terms of additional amendments to the WRTKA and judicial developments. Trial Tr. vol. III (AM), 110:20-112:6 (Wales); accord Trial Tr. vol. I (AM), 61:8-14, 77:13-88:2 (Nauser); Trial Tr. vol. I (PM), 46:24-47:7 (Nauser).

60. The passage of the APR Mandate at a time that Plaintiffs were struggling to meet the increased need for their services after the U.S. Supreme Court overturned Roe was, for Plaintiffs, beyond a bridge too far. Trial Tr. vol. I (AM), 124:1-10 (Nauser); Trial Tr. vol. III (AM), 110:20-112:6 (Wales); Pretrial Order, Index No. 630; at 10 (Def. Fact 46) (Plaintiff's experienced uptick in abortion demand, primarily from women in Texas, Oklahoma, Missouri, and Arkansas as well as women from Nebraska, Louisiana, and Iowa); *id.* (Def. Fact 51-52) (in FY2020, Planned Parenthood performed 4,004 medical abortions and 1,290 procedural abortions; in FY2024, they performed 10,030 medical abortions and 3,062 procedural abortions).

61. Plaintiffs seek to invalidate the WRTKA, including the APR Mandate (H.B. 2264), and the Reason Mandate (H.B. 2749) (together, "the Subject Laws"). Pretrial Order, Index No. 630; at 9 (Def. Fact 1). Plaintiffs Hodes & Nauser, MDs, P.A. and Dr. Nauser challenge the Subject Laws on behalf of themselves, their providers and staff,

and their patients. *Id.* at 9 (Def. Fact 8). Plaintiff Comprehensive Health of Planned Parenthood Great Plains ("Comprehensive Health") challenges the Subject Laws on behalf of itself, as well as its patients, physicians, and staff. *Id.* at 10 (Def. Fact 9).

62. Defendant Kris Kobach is the Attorney General and is responsible for defending Kansas laws against constitutional challenges. K.S.A. 75-702. As Attorney General, Defendant Kobach is the "chief law enforcement officer of the state" and "one of the state's prosecuting attorneys." *State ex rel. Miller v. Rohleder*, 208 Kan. 193, 194, 490 P.2d 374, 375 (1971); accord K.S.A. 22-2202(r) (2026). Pursuant to this prosecutorial power, Defendant Kobach may assist in the prosecution of and take over prosecutions of violations of Kansas criminal laws, upon the request of a District Attorney. See K.S.A. 75-704; *State ex rel. Stephan v. Reynolds*, 234 Kan. 574, 578, 673 P.2d 1188, 1192 (1984). Defendant Kobach is also authorized to assist in the prosecution of and take over prosecutions of any violation of the Kansas Healing Arts Act, upon the request of the Board of Healing Arts. See K.S.A. 65-2866.

63. Defendant Stephen M. Howe is the District Attorney for Johnson County, which includes Overland Park. As District Attorney, Defendant Howe is empowered to prosecute violations of the WRTKA occurring in Johnson County. See K.S.A. 22a-104 (district attorney duties); K.S.A. 22-2602 (place of trial). An act of unprofessional conduct also potentially exposes a physician to prosecution for a misdemeanor and monetary penalties for each separate offense. See K.S.A. 65-2862.

64. Defendant Marc Bennett is the District Attorney for Sedgwick County, which includes Wichita. As District Attorney, Defendant Bennett is empowered to

prosecute violations of the WRTKA occurring in Sedgwick County. See K.S.A. 22a-104, 22-2602, 65-2862.

65. Defendant Mark A. Dupree Sr. is the District Attorney for Wyandotte County, which includes Kansas City. As District Attorney, Defendant Dupree is empowered to prosecute violations of the WRTKA occurring in Wyandotte County. K.S.A. 22a-104, 22-2602, 65-2862.

66. Defendant State ex rel. Kansas Board of Healing Arts ("BOHA") is the agency responsible for enforcing violations of the WRTKA, which may be punishable as unprofessional conduct. See K.S.A. 65-6712, 65-2836(b) (describing the Board of Healing Arts' enforcement authority regarding unprofessional conduct); Pls.' Ex. 15 No. 4 (BOHA authority to take disciplinary action for unprofessional conduct) A physician guilty of unprofessional conduct may have their license "revoked, suspended or limited," "may be publicly censured or placed under probationary conditions," or may have their "application for a license or for reinstatement of a license . . . denied." K.S.A. 65-2836. The Board of Healing Arts is also empowered to enforce willful or repeated violations of either the WRTKA or the Reason Mandate. See K.S.A. 65-2836(f) (authorizing the Board of Healing Arts to take disciplinary action against a licensee who "has willfully or repeatedly violated . . . any rules or regulations of the secretary of health and environment that are relevant to the practice of the healing arts").

67. Defendant Janet Stanek, in her official role as Secretary of KDHE, is responsible for developing and maintaining the certifications required by the WRTKA and for publishing and distributing materials required by the WRTKA. See K.S.A. 65-6709(e), 6710; Pls.' Ex. 4 (Certification forms created by KDHE pursuant to the

WRTKA); Pls.' Ex. 5a (KDHE WRTK Handbook); Pls.' Ex. 5b (WRTK Directory of Available Services). She is also responsible, in her official role, for enforcing violations of Section (b) of H.B. 2264; and implementing and enforcing violations of the Reason Mandate. H.B. 2264 § 1(g); H.B. 2749 § (a), (b), (i); K.S.A. 65-454; Pls.' Ex. 17 No. 13 (Stanek effectuates and enforces laws passed by the legislature).

68. Plaintiffs filed this lawsuit and moved for a temporary injunction against enforcement of the WRTKA, including the APR Mandate. The State agreed not to enforce the APR Mandate pending this Court's ruling on Plaintiffs' temporary injunction motion. Stip. J. Entry (June 22, 2023). On October 30, 2023, this Court granted the motion in part, temporarily enjoining K.S.A. 65-6709, 65-6710(a)(3)-(a)(4), 65-6712, and the APR Mandate.

69. On July 1, 2024, with this Court's leave, Plaintiffs supplemented their petition to challenge the Reason Mandate. H.B. 2749. J. Entry (July 22, 2024); Suppl. 2d Am. Pet. (July 1, 2024). On July 29, 2024, the parties stipulated that KDHE and the State "shall not enforce H.B. 2749 until a final judgment," in exchange for Plaintiffs not seeking a temporary injunction against H.B. 2749 and a continuance of trial. Stip. (July 29, 2024).

Further Evidence Presented.

Witness Testimony.

70. Plaintiffs called eleven fact and expert witnesses in their case-in-chief, and they called two additional experts as rebuttal witnesses. Pursuant to K.S.A. 60-232(a), Plaintiffs also presented uncontroverted rebuttal testimony from four KDHE corporate representatives by deposition designation. Trial Tr. vol. VII (PM), 26:22-27:22.

71. **Dr. Traci Nauser** graduated from the University of Missouri-Kansas City in 1994 and completed her residency at the University of Missouri-Kansas City, Saint Luke's Hospital, and Truman Medical Center in 1998. Trial Tr. vol. I (AM), 19:5-19 (Nauser). Dr. Nauser's medical education and training included education on the principles of medical ethics and training on how to communicate and establish trust with patients. *Id.* at 20:25-21:8, 24:5-10 (Nauser). Although Dr. Nauser's residency program did not offer abortion training, she pursued that training on her own time during her residency. *Id.* at 20:7-16 (Nauser). Dr. Nauser has admitting privileges at Menorah Medical Center, where she regularly delivers babies and provides other hospital-based care to her patients. *Id.* at 22:5-14 (Nauser). Dr. Nauser is on the credentialing committee at Menorah Medical Center and has previously served as the chair of its obstetrics and gynecology department. *Id.* at 22:15-18 (Nauser). She also serves on the faculty of the University of Kansas. *Id.* at 22:19-23 (Nauser). Dr. Nauser has delivered almost 4,500 babies over the course of her career. *Id.* at 22:24-23:4 (Nauser). Dr. Nauser gave competent, credible, and reliable testimony, based on her qualifications and experience, about the standard of care for provision of abortion services, CWH's policies and practices for the provision of abortion care (including the process by which CWH obtains informed consent), the impacts of the Subject Laws on CWH and its patients, and the lack of comparable restrictions on her provision of other OB/GYN care. See generally Trial Tr. vol. I (AM) (Nauser); Trial Tr. vol. I (PM) (Nauser). The Court found her testimony to be extremely powerful and persuasive, given personal and professional experiences in this area and regarding issues relevant to this litigation.

72. **Ms. Lynnette Ranney** worked at CWH from July 2017 to November 2023. Trial Tr. vol. IV (AM), 9:10-13 (Ranney). As facility manager of CWH, she was responsible for processing paperwork for abortion patients and training and supervising front desk staff on compliance with the WRTKA. *Id.* at 10:2-11:3 (Ranney). She regularly interacted with abortion patients, held primary responsibility for processing WRTKA paperwork, and personally had to turn away patients whose paperwork did not meet the WRTKA's precise requirements. *Id.* at 10:12-14, 11:18-23, 20:17-19 (Ranney). Prior to the Temporary Injunction, Ms. Ranney would spend about seven hours in a typical workday processing WRTKA paperwork. *Id.* at 24:9-12. Based on her personal knowledge and experience, Ms. Ranney gave competent and credible testimony about the impacts of the WRTKA on CWH, its staff, and its patients. See generally Trial Tr. vol. IV (AM) (Ranney).

73. **Dr. Iman Alsaden** is the Chief Medical Officer at Comprehensive Health. Trial Tr. vol. I (PM), 57:12-58:24 (Alsaden). Dr. Alsaden graduated from medical school at the University of Illinois and completed their residency in OB/GYN at the University of Chicago. *Id.* at 55:24-56:5 (Alsaden). Dr. Alsaden is board certified in general OB/GYN and Complex Family Planning. *Id.* at 56:8-9 (Alsaden). Complex Family Planning is a field of OB/GYN that deals specifically with abortion care, complex contraception, pregnancy-related complications, and comprehensive reproductive health care, particularly for individuals with complex medical conditions or surgical histories. *Id.* at 56:12-15 (Alsaden); see also Trial Tr. vol. II (AM), 52:18-53:6 (Schreiber). Dr. Alsaden is licensed to practice medicine in Kansas, Oklahoma, Arkansas, and Missouri. Trial Tr. vol. I (PM), 59:21-22 (Alsaden). Dr. Alsaden has been providing abortion care for over

ten years. *Id.* at 56:16-20 (Alsaden). Based on their training and experience and knowledge of the literature, Dr. Alsaden is familiar with the applicable standard of care for providing abortion services. *Id.* at 60:1-5 (Alsaden). Dr. Alsaden is personally involved with training Comprehensive Heath staff on obtaining informed consent *Id.* at 68:5-19 (Alsaden). Dr. Alsaden testified credibly regarding their firsthand experience of the impacts of the WRTKA as a provider in clinic and as a chief medical officer. *Id.* at 78:24-79:8; 79:14-81:14, 83:6-84:8 (Alsaden). Based on their qualifications and experience, Dr. Alsaden also gave competent, credible, and reliable testimony about the standard of care for provision of abortion services, Comprehensive Health's policies for the provision of abortion care (including the process by which Comprehensive Health obtains informed consent), as well as the impacts of the Subject Laws on Comprehensive Health and its patients. See generally Trial Tr. vol. I (PM) (Alsaden); Trial Tr. vol. II. (AM) (Alsaden). Although they comply with the standard of care with respect to obtaining informed consent, Dr. Alsaden specifically has observed that Comprehensive Health's patients that present for abortion care have generally already thought about the issues and options relating to their pregnancy and have decided generally that they wish to proceed because they need and want that care for which they presented. Trial Tr. vol. II (AM), 86:21-87:13. Dr. Alsadan was a compelling and impressive witness, in terms of their professional experiences and resulting opinions related to this matter.

74. **Ms. Emily Wales** is the president and CEO of Comprehensive Health, Planned Parenthood Great Plains, Planned Parenthood of Arkansas and Eastern Oklahoma, and Planned Parenthood Great Plains Votes. Trial Tr. vol. II (PM), 107:8-9,

107:16-19 (Wales). In her role as president and CEO of these organizations, Ms. Wales reports to the board, provides general oversight of the organizations' operations, and ensures that they are upholding their mission. *Id.* at 108:1-6 (Wales). Before becoming CEO, Ms. Wales served as the general counsel for the organization and then as the COO. *Id.* at 108:21-24 (Wales). Ms. Wales worked at Comprehensive Health while the WRTKA was still in effect, beginning in 2017 and continuing through the time when the Temporary Injunction was put in place. *Id.* at 109:22-110:2 (Wales). Ms. Wales's testimony reflects her detailed, firsthand knowledge of the WRTKA's impacts on Comprehensive Health, its physicians and staff, and its patients. *Id.* at 126:15-127:1 (Wales); Trial Tr. vol. III (AM), 100:6-101:3 (Wales). Ms. Wales also testified about her familiarity with Comprehensive Health's planning to implement the APR Mandate and the Reason Mandate. Trial Tr. vol. III (AM), 20:3-26:6 (Wales). Based on her personal knowledge and her professional experience, Ms. Wales gave extremely competent and credibly testimony about the impact of the Subject Laws on Comprehensive Health and its patients. See generally Trial Tr. vol. II (PM) (Wales); Trial Tr. vol. III (AM) (Wales).

75. **Ms. Angela Huntington** worked as a patient navigator at Comprehensive Health from 2021 to 2024. Trial Tr. vol. IV (AM), 33:10-20 (Huntington). As a patient navigator, Ms. Huntington helped patients overcome barriers to accessing abortion care in Kansas, including by assisting them with procedure cost, travel, and lodging. *Id.* at 33:21-34:2, 37:6-18, 64:2-5 (Huntington). Ms. Huntington provided navigation assistance to both patients who lived in Kansas and patients who traveled to Kansas from other states. *Id.* at 35:7-20, 36:15-20 (Huntington). Ms. Huntington interacted directly with patients about the WRTKA's 24-hour informed consent form, including to

remind patients about the form and to reschedule travel and lodging for patients who arrived at their appointments without a form or with a form that was not properly completed. *Id.* at 38:9-19, 39:6-10, 41:2-12, 50:16-24, 56:24-59:22 (Huntington). Based on her personal knowledge and experience, Ms. Huntington provided competent and credible testimony regarding the impact of the WRTKA on Comprehensive Health, its patients, and its staff. See generally Trial Tr. vol. IV (AM) (Huntington).

76. **Dr. Courtney Schreiber** is a professor of obstetrics and gynecology at the University of Pennsylvania, as well as an attending physician and the Chief of the Division of Family Planning at Penn Medicine. Trial Tr. vol. II (AM), 51:5-10, 53:7-54:23 (Schreiber); Pls.' Ex. 62, at 3 (Schreiber CV). She received her M.D. from New York University School of Medicine and a master's degree in public health with a concentration in epidemiology from the University of Pittsburgh. Trial Tr. vol. II (AM), 51:25-52:13 (Schreiber); Pls.' Ex. 62, at 1 (Schreiber CV). Dr. Schreiber is board certified in OB/GYN and Complex Family Planning and is a member of the American College of Obstetricians and Gynecologists ("ACOG") and the Society of Family Planning ("SFP"). Trial Tr. vol. II (AM), 52:18-53:6, 58:18-59:3 (Schreiber); Pls.' Ex. 62, at 5, 7 (Schreiber CV). In her clinical practice, Dr. Schreiber provides the full range of gynecologic care, with a focus on family planning and pregnancy complications, including providing medication and procedural abortion and obtaining informed consent for abortion. Trial Tr. vol. II (AM), 54:12-55:8 (Schreiber). Dr. Schreiber also conducts clinical human subjects research (including clinical trials on the use of mifepristone for medication abortion), epidemiological research, and translational work (research examining "how things manifest biologically and thinking about . . . preclinical

hypotheses that we can test [and] then maybe would move to the bedside"). *Id.* at 55:21-56:11, 95:24-96:1 (Schreiber); Pls.' Ex. 62, at 33-81 (Schreiber CV). She has served as a peer reviewer for journals such as the Journal of Obstetrics and Gynecology, the American Journal of Obstetrics and Gynecology, Contraception, and Pharmacoepidemiology, and she also publishes extensively on topics such as abortion, including medication abortion; miscarriage management; and family planning methods, including "better ways of . . . counseling and advising people or patients on contraceptive methods." Trial Tr. vol. II (AM), 57:6-17, 58:8-17 (Schreiber); see also Pls.' Ex. 62, at 33-86 (Schreiber CV). Based on these qualifications, Dr. Schreiber provided very credible and reliable testimony regarding the biological implausibility of APR, the limited and, at best, low-quality evidence underlying the APR theory, the potential risks of APR, and the inaccurate and misleading nature of the disclosures about APR in the APR Mandate. See generally Trial Tr. vol. II (AM) (Schreiber); Trial Tr. vol. II (PM) (Schreiber). In fact, the Court found her testimony regarding APR theory compelling, as to why it is (given the existing literature and limited "studies") implausible, risky, and misleading to pregnant women. The Court found her testimony regarding the safety and efficacy of medication abortion (97-98% effective with exceedingly low complication rate), as well as a detailed explanation of the pharmacodynamics (i.e., a drug's effects on the body, including mechanisms of action and biological response) of medication abortion, to be equally powerful and credible.

77. **Dr. Matthew Wynia** is a physician, a professor of internal medicine and public health, and the director of the Center for Bioethics and Humanities at the University of Colorado Anschutz. Trial Tr. vol. IV (AM), 94:5-10 (Wynia). Dr. Wynia has

extensive experience teaching, researching, and publishing about medical ethics, including over 250 peer-reviewed publications. *Id.* at 100:21-102:6, 104:1-4, 104:11-24 (Wynia). He has served as the head of the Institute of Ethics at the American Medical Association. *Id.* at 95:19-96:22 (Wynia). He has held numerous leadership roles in professional organizations, including the American Society for Bioethics and Humanities, the American Public Health Association ("APHA"), and the American Board of Medical Specialties. *Id.* at 95:19-103:25 (Wynia). Dr. Wynia also draws his expertise from his clinical practice, including 18 years of focusing on treating patients with HIV. *Id.* at 99:2-100:20 (Wynia). Based on these qualifications, Dr. Wynia provided credible and reliable testimony regarding the principles of medical ethics and how the Subject Laws force providers to violate their medical ethical obligations. See generally Trial Tr. vol. IV (AM) (Wynia); Trial Tr. vol. IV (PM) (Wynia). The Court found Dr. Wynia's testimony on the trust-grounded nature of the physician-patient relationship and the need for patient-directed, relevant, accurate, and non-judgmental discussions in the confidential setting of healthcare decisions particularly compelling and persuasive. Similarly, his testimony on how the WRTKA disclosures are inconsistent with these ethical and practical issues was also persuasive to the Court, particularly as to his opinions that the disclosures were, at best, "roadblocks" to care and, at worst, constitute a practical "wall" that subverts the trust-dependent relationship.

78. **Dr. Lisa Lee** is an epidemiologist and public health ethicist with over thirty years of experience in public health practice and ethics. Trial Tr. vol. III (PM), 22:4-6, 25:16-26:26 (Lee); see generally Pls.' Ex. 67 (Lee CV). Dr. Lee obtained her master's in bioethics, which "cover[ed] research ethics, public health ethics and clinical ethics," from

Albany Medical College, and her Ph.D. in public health from Johns Hopkins University. Trial Tr. vol. III (PM), 22:23-23:3 (Lee); Pls.' Ex. 67, at 1 (Lee CV). She is currently employed at Virginia Polytechnic Institute and State University as the Senior Vice President for Research and Innovation, where she "directs a group that focuses on research ethics and research compliance," and as a professor of public health. Trial Tr. vol. III (PM), 23:4-11 (Lee); Pls.' Ex. 67, at 1 (Lee CV). Throughout her career, Dr. Lee worked in various epidemiological, ethical, and leadership roles at national and state public health authorities, including serving as the Chief Science Officer and Senior Ethics Consultant at the Centers for Disease Control and Prevention ("CDC") and serving as an epidemiologist in Maryland and Colorado's departments of public health. Trial Tr. vol. III (PM), 23:12-25:12 (Lee); Pls.' Ex. 67, at 1-5 (Lee CV). In her role as Chief Science Officer at CDC, Dr. Lee was responsible for the convening of surveillance scientists that examined and updated CDC's definition of public health surveillance. Trial Tr. vol. III (PM), 36:14-39:17 (Lee); Pls.' Ex. 67, at 2 (Lee CV). Additionally, Dr. Lee served as the inaugural chair of the Ethics Section of the APHA—the "oldest and largest national public health professional organization"—and led the development of the 2019 APHA Code of Ethics, the agreed-upon code of ethics used by public health professionals and ethicists. Trial Tr. vol. III (PM), 27:5-28:14, 31:19-32:10, 78:19-79:10 (Lee); Pls.' Ex. 67, at 14 (Lee CV). Based on these qualifications, Dr. Lee provided exceedingly credible and reliable testimony about how the Reason Mandate deviates from the methodological and ethical requirements for public health data collection, whether through public health surveillance, vital statistics registration, or public health research. See generally Trial Tr. vol. III (PM) (Lee). Of particular note, Dr. Lee's

explanations as to the definition of “public health surveillance” was notable and carries significant weight, given her distinguished qualifications and experience in this area. Her answers on both direct and cross examination, including her demeanor, demonstrated her subject-matter expertise, her logic, and her opinions—all of which the Court concludes are compelling and persuasive, with respect to the Reason Mandate and its validity and/or use (or lack thereof) for any purpose.

79. **Dr. Katrina Kimport** is a medical sociologist and professor in the Department of Obstetrics, Gynecology, and Reproductive Sciences at the University of California, San Francisco. Trial Tr. vol. III (AM), 118:15-19 (Kimport). Dr. Kimport received a bachelor’s degree in sociology from Yale University and a master’s and doctorate in sociology from the University of California, Santa Barbara. *Id.* at 118:20-25 (Kimport). Medical sociology is a subdiscipline of sociology that uses the theories and methodologies of sociology to examine phenomena of health and illness, of the delivery of health care, and of differential access to medical resources. *Id.* at 119:7-12 (Kimport). Dr. Kimport is a member of the American Sociological Association and a member of SFP. *Id.* at 121:15-24 (Kimport). Dr. Kimport has published over 90 articles in peer reviewed academic journals and three books, with an additional book forthcoming. *Id.* at 119:19-120:1 (Kimport). The research that Dr. Kimport has engaged in and published in peer-reviewed venues includes research studies that have looked at people’s experience of seeking abortion care, choosing abortion care, and receiving abortion care, and then after the fact, how they understand, talk about, and experience having had an abortion. *Id.* at 120:2-121:1 (Kimport). Dr. Kimport has interviewed roughly 240 patients who considered or obtained an abortion. *Id.* at 123:12-16 (Kimport). Based on

these qualifications, Dr. Kimport offered credible and reliable testimony that the Reason Mandate would likely lead to an increase in abortion stigmatization, which is harmful to abortion patients, and rebuttal testimony on the mental and emotional health outcomes of abortion. See generally Trial Tr. vol III (AM) (Kimport); Trial Tr. vol. VII (PM) (Kimport). Further, the Court found Dr. Kimport's rebuttal testimony on whether abortion patients feel "regret" for terminating their pregnancy persuasive and of far greater credibility than opposing testimony from Dr. Wubbenhorst. Her prospective study (Turnaway study), as described through her testimony, was helpful and credible to support the conclusion that women do not, by and large, regret their reproductive decisions post-abortion. While they may have some negative emotions due to social circumstances attendant to their pregnancy status, the vast majority of women feel positive emotions following abortion—with approximately 95% reporting that their choice was the "right one" for them. And Dr. Kimport's testimony distinguishing between the literature relied upon by Dr. Wubbenhorst and the literature on which she relied further demonstrates, at least in part, why her testimony merits greater weight.

80. **Professor Nadia Sawicki** is a legal scholar specializing in torts, health law, and bioethics. She holds both a J.D. and a master's degree in bioethics from the University of Pennsylvania. Trial Tr. vol. II (PM), 48:18-49:3, 50:2-51:1 (Sawicki); see generally Pls.' Ex. 63 (Sawicki CV). Professor Sawicki has over 15 years of researching, teaching, and publishing on informed consent, including the historical development of the common law doctrine. Trial Tr. vol. II (PM), 49:11-51:1, 54:6-15 (Sawicki); see generally Pls.' Ex. 63 (Sawicki CV). Professor Sawicki is currently the Beazley Chair in Health Law and Georgia Reithal Professor of Law at Loyola University of Chicago

School of Law, where she has taught for over a decade. Trial Tr. vol. II (PM), 47:3-11, 47:17-19 (Sawicki). Since 2019, Professor Sawicki has served as an Advisor to the American Law Institute on its new section on Medical Malpractice in the Restatement Third of Torts, which includes sections on informed consent. *Id.* at 52:1-52:10 (Sawicki). She is also a co-editor of one of the leading health law casebooks—Hall, et al., Health Care Law and Ethics. *Id.* at 49:20-50:1 (Sawicki). Based on these qualifications, Professor Sawicki provided credible and reliable testimony about the history and development of the common law doctrine of informed consent, and the extent to which the mandated disclosures in the Subject Laws are inconsistent with that tradition of informed consent and its underlying principles. See generally Trial Tr. vol. II (PM) (Sawicki). While the Court is already intimately familiar with the laws of informed consent in the medical context (in Kansas), the Court found Ms. Sawicki's testimony helpful to place some of the critical issues in proper historical and legal context and to better understand the evidence.

81. **Dr. Nicholas Syrett** is a historian specializing in gender, sexuality, and childhood in the 19th and 20th century United States, particularly the ways that gender and sex are regulated by the law and the consequences of those laws for Americans. Trial Tr. vol. IV (PM), 49:12-14 (Syrett); see generally Pls.' Ex. 64 (Syrett CV). Dr. Syrett has over two decades of experience teaching, researching, and publishing about the historical regulation of gender, sexuality, marriage, and reproduction in the country, including the history of abortion regulation. Trial Tr. vol. IV (PM), 49:15-51:1 (Syrett); see generally Pls.' Ex. 64 (Syrett CV). Dr. Syrett currently serves as a professor and Chair of the Department of Gender and Women's Studies at the University of Wisconsin-

Madison. Trial Tr. vol. IV (PM), 47:20-25, 48:10-18 (Syrett). He previously taught in the Women, Gender, and Sexuality and History departments at the University of Kansas for 11 years, including serving as Chair of the Department of Women, Gender, and Sexuality Studies for five years. *Id.* Dr. Syrett has published four historical monographs (single-author books) on subjects including the history of an abortion provider in 19th century New York and the campaign to criminalize abortion, and the history of legal minors and marriage, including in Kansas. *Id.* at 50:3-20 (Syrett); see generally Pls.' Ex. 64 (Syrett CV). He has also published two dozen peer-reviewed articles and book chapters in edited volumes on gender, sexuality, marriage, reproduction, and childhood. Trial Tr. vol. IV (PM), 50:21-51:1 (Syrett); see generally Pls.' Ex. 64 (Syrett CV). As a historian, Dr. Syrett relies on primary and peer-reviewed secondary sources to—among other things—identify patterns (or breaks in patterns), including patterns in societal attitudes over time. Trial Tr. vol. IV (PM), 51:6-53:18 (Syrett). Based on these qualifications and sources, Dr. Syrett provided credible and reliable testimony about the history of reproductive control measures in the United States and in Kansas, and that such measures are often based on and reinforce sex stereotypes. See generally Trial Tr. vol. IV (PM) (Syrett). Dr. Syrett further testified credibly and reliably that the Subject Laws perpetuate that legacy of reproductive control over women and harmful sex stereotyping. See generally *id.* In that respect, the Court found that Dr. Syrett's testimony was helpful to better understand some of the evidence on why and how the Subject Laws are/were stigmatizing and perpetuated sex stereotypes and/or paternalistic views on healthcare related decisions made by women.

82. **Dr. Steven Ralston** is a board-certified OB/GYN and maternal-fetal medicine ("MFM") provider. Trial Tr. vol. VII (AM), 59:1-8 (Ralston). MFM is a subspecialty of obstetrics and gynecology that focuses on higher-risk pregnancies. *Id.* at 54:23-55:7 (Ralston). Dr. Ralston currently serves as the Division Director for Maternal-Fetal Medicine at George Washington University, where he also serves as a professor of obstetrics and gynecology. *Id.* at 54:20-22 (Ralston). Dr. Ralston holds an undergraduate degree in molecular biophysics and biochemistry from Yale University and a medical degree from Columbia University. *Id.* at 57:5-9 (Ralston). Dr. Ralston completed an OB/GYN residency at Yale-New Haven Hospital and an MFM fellowship at Tufts-New England Medical Center. *Id.* at 57:9-13 (Ralston). Dr. Ralston is a member of ACOG and the Society for Maternal-Fetal Medicine ("SMFM"). *Id.* at 58:16-25 (Ralston). In his MFM practice, Dr. Ralston performs fetal procedures, including both diagnostic procedures and therapeutic procedures, and observes fetal behavior every day, including observing how fetuses react to external stimuli. *Id.* at 61:2-63:21 (Ralston). Dr. Ralston also provides abortions, including both medication and procedural abortions. *Id.* at 65:5-15 (Ralston). Dr. Ralston gained expertise in fetal development as part of his training to become an MFM and through review of scientific literature relating to fetal pain, including literature on fetal development and on the physiological mechanisms necessary to feel pain. *Id.* at 63:22-64:4, 64:12-65:4 (Ralston). Dr. Ralston is the co-author of a review article published by SMFM and SFP that addresses the issue of fetal pain. *Id.* at 77:9-24 (Ralston); Pls.' Ex. 73 (SMFM, Use of Analgesia & Anesthesia for Maternal-Fetal Procedures). Dr. Ralston also has specialized training in medical ethics and bioethics, including a Master of Public Health from Boston University

with a concentration in health law, bioethics, and human rights. *Id.* at 57:13-16, 57:23-24, 66:6-67:12 (Ralston). Dr. Ralston provided credible and reliable testimony regarding fetal development and the physiological mechanisms necessary to feel pain, including credible testimony that the WRTKA's mandated disclosures about fetal pain are false and misleading. See generally Trial Tr. vol. VII (AM) (Ralston). Dr. Ralston's opinions and testimony were exceptionally compelling, particularly when contrasted by the State Defendants' witnesses. He has actual, real-world experience in the area of fetal development (in stark contrast to the State's witnesses), and his education, training, experience, and expertise was far superior on "fetal pain" issues to anyone presented by the State. And he presented, through both his substantive testimony and his demeanor while testifying, as a medical expert that had no particular "bent" or agenda to pursue, other than to testify objectively to the views of the mainstream medical and scientific communities in this particular subspecialty area.

83. **Dr. Cynthia Daniels** is a political scientist with over 30 years of experience and is the director of the Informed Consent Project. Trial Tr. vol. III (PM), 95:7-11; 97:5-98:17 (Daniels); see generally Pls.' Ex. 61 (Daniels CV). Dr. Daniels obtained her master's and Ph.D. in political science from University of Massachusetts at Amherst. *Id.* at 98:18-99:1 (Daniels). Throughout her career, Dr. Daniels has published research on social or political problems related to reproductive health issues for both men and women. *Id.* at 99:14-22, 100:12-17 (Daniels). Based on these qualifications, Dr. Daniels provided credible and reliable testimony regarding the Informed Consent Project's methodology and results, which were admitted without objection. See generally Trial Tr. vol. III (PM) (Daniels); see also pg. 118:10 to 119:5. Notably, the

results of a study she oversaw were reported in a scholarly journal article, which was admitted into evidence by stipulation, reflected that over 43% of the statements contained in the WRTKA disclosures analyzed (106 total) were considered "medically inaccurate" by the expert panel convened to review state disclosures of this kind. *Id.* at 116-120.

84. **Dr. Farah Ahmed** has worked at KDHE since 2010 and currently serves as KDHE's State Epidemiologist and Environmental Health Officer as well as Co-Bureau Director for the Bureau of Epidemiology & Public Health Informatics and the Chair of the Institutional Review Board ("IRB"). Pls.' Dep. Desigs. vol. 1, Ex. A, Ahmed (KDHE) Dep. 11:7-12, 12:1-12 (May 19, 2025). In these roles, Dr. Ahmed oversees epidemiological work in areas including "injury, overdose epidemiology, trauma epidemiology, chronic disease, maternal and child health, environmental health, infectious disease epidemiology"; responds to legislative inquiries; helps potential investigators discern whether particular activities need IRB review; and tracks all the projects that the KDHE IRB "has reviewed and has oversight over," among other responsibilities. *Id.* at 13:5-19:4. Dr. Ahmed holds a B.S. in biology, a master's in public health, and a Ph.D. in epidemiology. *Id.* at 10:24-11:7. The Court credits Dr. Ahmed's uncontroverted rebuttal testimony, which was presented by deposition designation. Trial Tr. vol. VII (PM), 26:22-27:22.

85. **Ms. Amy Dean-Campmire** is the Director of KDHE's Bureau of Family Health within the Division of Public Health and previously served as the Director for the Bureau's Children and Families Section from 2023 to approximately 2024. Pls.' Dep. Desigs. vol. 1, Ex. B, Dean-Campmire (KDHE) Dep. 12:7-17 (May 19, 2025). In her role

as Bureau director, Ms. Dean-Campmire oversees programs like the "Title V block grant, maternal child health activities, newborn screening, birth defects, . . . our Part C early intervention program, home visiting programs, family planning, [and] teen pregnancies," including various public health surveillance systems that "monitor and track services and outcome" to assess the efficacy of these programs. *Id.* at 12:23-15:3. Ms. Dean-Campmire had similar responsibilities in her role as section director. *Id.* at 15:4-17. The Court credits Ms. Dean-Campmire's uncontroverted rebuttal testimony, which was presented by deposition designation. Trial Tr. vol. VII (PM), 26:22-27:22.

86. **Mr. Matt Lara** has served as KDHE's Chief of Staff from 2023 to present, Director of Communications and Legislative Affairs from 2022 to 2023, and Communications Director from 2021 to 2022. Pls.' Dep. Desigs. vol. 2, Ex. C, Lara (KDHE) Dep. 12:20-13:3 (May 19, 2025). As Chief of Staff, Mr. Lara oversees the communications and legislative affairs teams and "help[s] make [KDHE's] legislative decisions in partnership with the governor's office," among other responsibilities. *Id.* at 13:4-14:9. Mr. Lara had similar responsibilities in his role as Director of Communications and Legislative Affairs. *Id.* at 14:10-18. The Court credits Mr. Lara's uncontroverted rebuttal testimony, which was presented by deposition designation. Trial Tr. vol. VII (PM), 26:22-27:22.

87. **Dr. Christina Smith** has served as the Director of Vital and Health Statistics and Data Analysis within KDHE's Division of Public Health for three years. Pls.' Dep. Desigs. vol. 2, Ex. D, Smith (KDHE) Dep. 12:8-17 (May 19, 2025). She "oversee[s] a team of data analysts, . . . making sure that we produce required reports on time," including reports for vital record data. *Id.* at 13:3-14:1. She holds

undergraduate degrees in Mathematics and Education and graduate degrees in Statistics. *Id.* at 10:19-11:6. The Court credits Dr. Smith's uncontroverted rebuttal testimony, which was presented by deposition designation. Trial Tr. vol. VII (PM), 26:22-27:22.

88. **Dr. Selina Sandoval**, Comprehensive Health's Associate Medical Director and one of Comprehensive Health's corporate representatives, was called in the State's case-in-chief as an adverse witness. The State called Dr. Sandoval to provide limited live testimony about average wait times for abortion patients at Comprehensive Health and to authenticate the videos Comprehensive Health uses as part of its education process. Trial Tr. vol. VI (AM), 6:18-10:7 (Sandoval). Dr. Sandoval also provided competent and credible testimony that since the WRTKA was enjoined, patients have been able to get same-day appointments at Comprehensive Health's health centers. *Id.* at 10:22-11:15.

89. Additionally, the State called three fact witnesses who were former abortion patients and four expert witnesses.

90. **Ms. Sheryl Hoyle** had an abortion in Salina, Kansas in 1972, over 20 years before the WRTKA first went into effect. Trial Tr. vol. IV (PM), 126:16-21, 127:19-22, 147:25-148:5 (Hoyle). None of the laws being challenged in this case applied to care that she received. *Id.* at 148:24-149:12 (Hoyle). Ms. Hoyle has never received medical care from Plaintiffs. *Id.* at 148:6-17 (Hoyle). Ms. Hoyle has never testified before, nor submitted written testimony to, the Kansas Legislature. *Id.* at 148:18-23 (Hoyle). Ms. Hoyle now oversees an "abortion recovery program" at Open Door Health Services in Hutchison, Kansas, which also embraces and provides abortion pill reversal.

Id. at 134:3-15 (Hoyle). Ms. Hoyle believes that abortion "takes the life of a child" and held the same view at the time that she received her abortion. *Id.* at 149:18-22, 150:20-23 (Hoyle). She testified that she would "like to see abortions stopped completely." *Id.* at 150:1-13 (Hoyle). The Court believes that her testimony on the substance of the WRTKA, the Reason Mandate questions, and her current recollections of her past experiences at the time of her abortion were significantly influenced by the obvious philosophical biases she has developed in the intervening 50+ years since she had her own abortion. Her testimony, in that regard, presented as less credible and not reliable to the Court—having considered both the substance as well as her demeanor while testifying.

91. **Ms. Melissa Cole** testified that she had three abortions, none of which took place in Kansas. Trial Tr. vol. V (AM), 53:13-15 (Cole). The first took place in Kansas City, Missouri in 1974; the second in Fayetteville, Arkansas in 1981; and the third in Texas in 1984. *Id.* at 7:7-11, 10:16, 54:9-21, 55:6-9 (Cole). She has no experience with the informed consent process for abortion care in Kansas. *Id.* at 53:18-25 (Cole). Ms. Cole disclosed her third abortion for the first time while testifying at trial; she did not disclose this abortion in her deposition. *Id.* at 55:23-56:15, 56:7-9, 57:25-58:17 (Cole). On direct examination, Ms. Cole testified that when she had her second abortion, while an adult, she "didn't know [her pregnancy] was a baby," *id.* at 20:20-21:8 (Cole), but on cross examination she testified that she did know at the time of her abortion that her second pregnancy was a "baby," and that she could just have a "baby" another time. *Id.* at 54:9-19 (Cole). The Court finds that the material omission of Ms. Cole's third abortion from her deposition testimony and her inconsistent testimony also

significantly undermines her credibility and is indicative of her personal biases. And her testimony regarding her knowledge base at the times of her abortions and her recollections of those events seemed unbelievable and coached, given her demeanor while on the stand. Indeed, Ms. Cole presented, as did these other witnesses that the State Defendants presented to discuss their prior abortion experiences, as having a strong agenda and potentially ulterior motivations for their testimony. Ms. Cole has never provided testimony to the Kansas Legislature about any of the laws challenged in this case. *Id.* at 59:16-21 (Cole). Ms. Cole has not read the WRTKA and instead assumed that it contained truthful information that would be beneficial to abortion patients based only on the title of the Act. *Id.* at 59:22-23, 62:9-20 (Cole). Ms. Cole believes that abortion should be illegal in all circumstances, including in cases of rape or incest. *Id.* at 59:9-15 (Cole). The Court believes that her testimony on the substance of the WRTKA, the Reason Mandate, and what she recalls her experiences were at the time of her abortions was significantly influenced by her obvious philosophical biases that she has developed in the intervening 40+ years since she had her multiple abortions. Her testimony, in that regard, presented as less credible and not reliable to the Court—having considered both the substance as well as her demeanor while testifying.

92. **Ms. Donna Pond** had an abortion in Kansas in 1986. Trial Tr. vol. V (AM), 68:24-25 (Pond). None of the laws challenged in this case applied to care that she received. *Id.* She received care from Dr. George Tiller's clinic, not from Plaintiffs. *Id.* at 69:24-70:2 (Pond). Ms. Pond testified that at the time of her abortion, she "didn't care if [she] had any other information, [she] just wanted to have the abortion as soon as

possible." *Id.* at 75:3-9 (Pond). The Court believes that her testimony on the substance of the WRTKA, the Reason Mandate, and what she recalls her experiences were at the time of her abortion was significantly influenced by her obvious philosophical biases that she developed in the intervening roughly 40 years since she had her abortion. Ms. Pond's statements were, at times and in material respects, internally inconsistent and unbelievable. Compare Trial Tr. vol V (AM), 75:5-9 (Pond) (Pond didn't need any other information and just wanted to have an abortion) with *id.* at 83:1-12 (Pond would have withdrawn her consent if she knew she could). Her testimony, in that regard, presented as not credible and not reliable to the Court—having considered both the substance as well as her demeanor while testifying.

93. Having carefully considered their testimony, the Court finds that the testimony of former abortion patients Sheryl Hoyle, Melissa Cole, and Donna Pond to be of marginal, if any, relevance to issues in this case, and affords their testimony no weight. None of these witnesses received abortion care from Plaintiffs or received abortion care subject to the WRTKA. Trial Tr. vol. IV (PM), 126:16-21, 127:19-22, 147:25-149: 12 (Hoyle); Trial Tr. vol. V (AM), 53:13-25 (Cole); Trial Tr. vol. V (AM), 68:24-25 (Pond). Their testimony appeared biased and untrustworthy to the Court, when considered either independently or in totality. Their testimony (along with the additional three that were not permitted to testify) appeared to be offered to further a narrative that was broadly unrelated to the claims/issues and the specific laws in dispute ***in this case***. Even if the Court were to have accepted, as true, their recitations of their personal experiences (the Court did not find them credible, given their demeanor, their inconsistency and sometimes unbelievable testimony, and also their answers to the

questions on cross examination), such testimony has essentially no probative value with respect to the issues raised ***in this case***. There is no evidence that the legislatures that enacted or amended the WRTKA or the Reason Mandate were aware of—much less motivated by—the personal experiences of these witnesses. While the Court certainly appreciates their appearances to convey their personal stories, as well as their subjective opinions on what they might or might not find helpful now as to their prior decisions to proceed with terminating their pregnancies, their hindsight reflections presented at trial simply are neither credible nor probative of any matter that the Court is required to address as part of these proceedings.

94. **Dr. Monique Chireau Wubbenhorst** is a board-certified OB/GYN licensed in Indiana and North Carolina. Defs.' Ex. 117 (Wubbenhorst CV). During her 30-year career, Dr. Wubbenhorst has worked at approximately 30 different hospitals in in the U.S., most in locum tenens positions. Defs.' Ex. 117 (Wubbenhorst CV); Trial Tr. vol. V (PM), 96:21-97:4 (Wubbenhorst). She is currently affiliated with the de Nicola Center for Ethics and Culture at Notre Dame, a "leading organization within the Catholic Intellectual Tradition on Ethics and Culture," where she has contributed to the Center's pro-life policy briefs. Defs.' Ex. 117 (Wubbenhorst CV); Trial Tr. vol. V (AM), 102:7-14 (Wubbenhorst), Trial Tr. vol. V (PM), 98:4-13 (Wubbenhorst). Dr. Wubbenhorst's own clinical and research experience with abortion is extremely limited. See Trial Tr. vol. V (PM), 89:10-90:6 (Wubbenhorst) (acknowledging she has never performed an abortion, obtained informed consent for abortion, or given information about abortion to one of her patients and that she observed an abortion only once, during her residency, over 30 years ago); *id.* at 95:18-96:4 (Wubbenhorst) (authored no peer-reviewed articles on

abortion in the U.S.). Although Dr. Wubbenhorst attempted to rebut Plaintiffs' evidence that abortion is safe, she ultimately acknowledged that, in her 30-year career, she has cared for a total of 25-30 patients in the U.S. experiencing what she believed to be abortion complications.[6] *Id.* at 92:5-95:17 (Wubbenhorst) (attempting to recast prior testimony about number of abortion complications she has treated).

95. Despite her limited experience with abortion, Dr. Wubbenhorst opined that, in her personal view, "unique concerns" apply to informed consent to abortion, that various disclosures mandated by the WRTKA are "relevant" to abortion, and that the Subject Laws serve a State's asserted interests in protecting maternal health and safety, protecting the vulnerable from coercion and abuse, upholding the integrity of the medical profession, and "show[ing] respect for prenatal life." Trial Tr. vol. V (PM), 12:23-13:4, 50:5-53:5, 59:18-62:3 (Wubbenhorst). Although Dr. Wubbenhorst obtained a master's degree in public health, she has never been employed by a state or local public health department (or as a vital registrar), and she did not speak to anyone from KDHE or review any of KDHE's testimony, in forming her opinions about the Reason Mandate. Trial Tr. vol. V (PM), 104:12-106:13 (Wubbenhorst). Dr. Wubbenhorst appeared to suggest that she was engaged in public health "surveillance" at a community health center when she personally participated in "go[ing] to a crack house

[6] Indeed, Dr. Wubbenhorst gave trial testimony inconsistent with her prior sworn testimony in another matter, and she was impeached with that prior testimony. While she attempted to explain away her prior inconsistent testimony, the Court found her parsing to be constantly evasive on cross examination and lacking credibility, and thus, it further undermined her testimony.

and find[ing] a mother there with the placenta still inside her and the baby gone." *Id.* at 103:8-13, 103:22-104:11 (Wubbenhorst).[7]

96. Beyond her limited and marginally-relevant experience relative to the issues of abortion informed consent, Dr. Wubbenhorst's opinions were often not supported by reasonably reliable evidence. For instance, in offering her opinion about abortion mortality rates, she relied on a study that tracked women who had abortions and then died within the next eight years—counting all deaths, regardless of cause. See, *e.g.*, Trial Tr. vol. V (PM), 109:24-110:10, 112:15-23 (Wubbenhorst). Further, many of her opinions are also well outside the mainstream, given the totality of evidence adduced at trial. For example, Dr. Wubbenhorst claimed that abortion mortality rates are many times greater than mortality rates for continued pregnancy and childbirth, *id.* at 138:7-23 (Wubbenhorst), which is contradicted by a wealth of admitted evidence, and is broadly not consistent with the mainstream medical consensus—e.g., Pls.' Ex. 68, at 74-76 (NASEM, The Safety and Quality of Abortion Care in the U.S.). Furthermore, Dr. Wubbenhorst's opinions about an alleged association between abortion and regret were based on research Dr. Kimport aptly summarized as "scientifically invalid." Trial Tr. vol. VII (PM), 9:3-12 (Kimport); see also *id.* at 19:4-21:20 (Kimport) (explaining flaws in studies on which Dr. Wubbenhorst relied, including improper controls, improper or lack of comparators, compound questions, and reliance on retrospective data when high quality prospective research on the same issues has been done). Having evaluated the

[7] Dr. Wubbenhorst's understanding of what "public health surveillance" actually entails appeared significantly at odds with what the evidence reflected as the mainstream and common understanding of such matters. See Testimony of Dr. Lee, Trial Tr. Vol. III (pm), pg. 37:9 to 39:17; Exhibit 90. The Court finds that her testimony on such issues was, at best, significant inflammatory "puffery," in an effort to overstate her actual qualifications and experience to address the purported "public health surveillance" purposes that the State Defendants and their attorneys seek to manufacture after the fact.

evidence, the Court concurs with Dr. Kimport's conclusions regarding the research relied upon by Wubbenhorst. Her testimony also likely misrepresented the findings and/or conclusions of studies or interpreted the findings of studies in ways the studies' authors cautioned against. See, *e.g.*, Trial Tr. vol. V (PM), 113:16-117:9, 118:2-7 (Wubbenhorst) (interpreting study about abortion complications as support for her opinions where authors cautioned "complications" included any encounter with the health care system); *id.* at 118:14-119:22 (Wubbenhorst) (relying on study about increased risks associated with delayed abortion care, which recommended increased access to early abortion to address that risk); *id.* at 122:21-124:13 (Wubbenhorst) (offering opinion that abortion "regret" is widespread and common and relying on study about abortion and regret whose conclusions "do not support recent claims from pro-life advocates that large numbers of women who have abortions regret their decisions").

97. Dr. Wubbenhorst's opinions about the Subject Laws, to the extent such opinions are even relevant to the applicable legal analysis, were often conclusory, incongruous with the actual statutory requirements, and generally failed to explain the need for such requirements when imposed solely in the abortion context. For instance, Dr. Wubbenhorst believes the WRTKA supports "women's health" and "safety" even though it requires patients to wait a minimum of 24-hours before treatment and despite her admission that the risks of abortion significantly increase the longer a patient is pregnant. Trial Tr. vol. V (PM), 51:22-52:7; 138: 3-23 (Wubbenhorst). Relatedly, she opined that the WRTKA requirements, particularly the "perinatal hospice" disclosures, served a beneficial interest, but effectively conceded the obvious under-inclusiveness of the provisions. See, Trial Tr. vol. V (PM), 124:18-126:6 (Wubbenhorst) (opining that all

patients who receive a lethal fetal diagnosis for their fetus should be informed about perinatal hospice but acknowledging that the WRTKA applies only to any pregnant person seeking abortion and that she is not aware of any Kansas law that mandates such disclosure to all pregnant patients, regardless of whether the patient is seeking an abortion).

98. Similarly, Dr. Wubbenhorst opined that the Reason Mandate protects maternal health and safety based on her belief that it is "important" to "protect" patients in domestic violence situations "from homicide," despite acknowledging that the Reason Mandate is purportedly a public health data collection law—not a requirement to screen patients for coercion or abuse. Compare Trial Tr. vol. V (PM), 59:18-61:4 (acknowledging that the Reason Mandate "has to do with data collection"), with *id.* at 107:13-109:23 (relying on ACOG recommendation that providers screen women and girls for reproductive and sexual coercion at visits like annual exams, new patient visits, and during obstetric care), and Pls.' Ex. 205 (ACOG Committee Opinion 554) (emphasizing the need to take a sensitive approach to screening and avoid re-traumatizing language).

99. The Court finds Dr. Wubbenhorst's opinions in this case to be biased, inconsistent in material respects, unreliable, and broadly not credible. Her highly-limited clinical experience with abortion, lack of relevant experience in public health surveillance, reliance on statements taken out of context, and apparently poor grasp of the relevant scientific literature undermine the reliability of her opinions. Moreover, her testimony was often non-responsive, and she frequently avoided direct answers to simple questions—instead defaulting to proffering self-serving testimony to avoid (or at

least delay and obfuscate) obvious admissions. *E.g.*, Trial Tr. vol V (PM), 85: 3-25 (Wubbenhorst) (pointing out a sentence was cut off rather than affirmatively identifying the sentence, written by her, that was visible); *Id.* at 87: 11-25 (distinguishing between abortion, intentional feticide, and termination of pregnancy); *Id.* at 90:19-91:25 (attempting to avoid answering whether she had ever counseled a patient regarding the benefits of abortion). In totality, the Court finds that Dr. Wubbenhorst showed a clear bias against abortion that simply cannot be divorced from the opinions she offered. See Trial Tr. vol. V (PM), 86:11-88:6 (Wubbenhorst) (opining that abortion is not health care, is harmful to women, and should not be permitted except where the intent is to save the pregnant person's life). After careful consideration of the foregoing, the Court finds that Dr. Wubbenhorst's testimony should be afforded essentially no weight, given its lack of credibility and reliability.

100. **Dr. Robin Pierucci** is a semi-retired neonatologist,[8] whose education, training, clinical practice, and research prior to retirement focused on care for neonates (newborns) and children. Trial Tr. vol. VI (AM), 12:9-16, 13:7-9, 14:11-17:13, 42:6-23 (Pierucci). Dr. Pierucci opined at trial that the required WRTKA Handbook's disclosures about fetal development and fetal pain are accurate and non-misleading and that the standard of care is to treat pain in liveborn neonates. See generally *id.* at 20:7-41:23, 42:24-43:8, 47:1-11 (Pierucci). The Court finds that Dr. Pierucci's opinions regarding fetal development and fetal pain in utero are entitled to little-to-no weight, based on deficiencies in her experience, qualifications, and evident personal bias. Dr. Pierucci

[8] Neonatology is the subspecialty of medicine that deals with newborn infants in the immediate aftermath of delivery—normally considered through the first few weeks of life.

conceded that OB/GYNs care for in-utero fetuses, and Maternal Fetal Medicine specialists (MFMs) perform fetal surgery and care for higher-risk pregnancies/fetuses; she is neither. *Id.* at 43:9-44:19 (Pierucci). She has no training or experience in performing fetal surgery, has not conducted any research regarding fetal surgery, outside of preparing her testimony for this case, and has not conducted any clinical or primary research regarding care for fetuses in utero. *Id.* Dr. Pierucci is also not an anesthesiologist or pain management specialist, has never provided anesthesia to a fetus in utero, and has not conducted any clinical research regarding anesthesia for fetuses in utero. *Id.* at 44:20-45:8 (Pierucci). Nor is she an embryologist, human anatomist, or neuroscientist; her only training in fetal development occurred during her fellowship in neonatology and through "embryologic textbooks and ongoing exploration and discussion about the children that were in my care." *Id.* at 17:14-22, 45:9-14 (Pierucci). Other than a position statement for the American College of Pediatricians ("ACPeds"),[9] Dr. Pierucci has only published two articles on fetal pain, both of which were published in journals associated with anti-abortion groups. *Id.* at 17:23-25, 49:20-23, 51:2-52:11 (Pierucci). Dr. Pierucci also personally believes abortion is "morally wrong" and "accessed too quickly and too easily." *Id.* at 19:18-25, 47:22-48:22, 48:25-51:7 (Pierucci). Dr. Pierucci agrees that her opinions regarding fetal pain are entirely inconsistent with the major medical professional associations of practitioners that

[9] According to her testimony, ACPeds is a small anti-abortion organization of professionals that has been designated a hate group by the Southern Poverty Law Center. Dr. Pierucci acts as the "Chair of the Pro-Life Committee" currently, and she is also "Co-Director of the Pro-Life Council" for that organization.

actually address fetal health, such as ACOG, SMFM, and RCOG, and she attributes that to the differences with the neonatal standard of care. *Id.* at 46:19-47:7.

101. Dr. Pierucci's opinion is that the most likely age for fetal nociception (i.e., a fetus' *autonomic* motor response to noxious stimuli detected by peripheral sensory receptors—see Exhibit 71, 73) onset is 20 to 22 weeks gestational age, which is 22 to 24 weeks LMP. *Id.* at 55:20-56:5. Even if this were somehow relevant to a pain experience (it is not), this opinion on the timeframe is beyond the gestational ages during which abortion is generally legal in Kansas, absent emergency/extenuating circumstances for the mother. See K.S.A. 65- 6703.

102. The Court concludes that Dr. Pierucci's opinions regarding fetal development and fetal pain are unlikely to be accurate and are certainly outside of the medical mainstream, which is not surprising, given her lack of experience in the subspecialties that actually deal with fetal development, health, and well-being. Perinatology and neonatology are distinct and different subspecialties for a reason. And even if her fetal pain opinions were somehow supportable by reliable admissible evidence, her conclusions on when a fetus is likely able to experience "pain" would be beyond the time during which Kansas currently permits abortions, absent exceptional circumstances. Thus, her testimony was irrelevant and not helpful.

103. **Dr. Maureen Condic** is an animal biologist whose professional publications have exclusively "involved animal research." Trial Tr. vol. VI (AM), 93:7-8, 121:21-25 (Condic). Dr. Condic has no clinical experience or training in patient care or communication. *Id.* at 93:10-19, 116:17-20 (Condic). Dr. Condic opined that the WRTKA's mandated disclosures that "abortion terminates the life of a whole, separate,

unique living human being" and regarding fetal pain are scientifically accurate and not misleading. *Id.* at 74:23-75:10, 90:13-20, 91:12-19, 92:15-20 (Condic). She also opined that "unborn child is a commonly understood term for humans at prenatal stages of development," but admitted on cross examination that this is her "personal opinion." *Id.* at 83:8-23, 115:16-116:20 (Condic).

104. The Court gives little weight to Dr. Condic's opinions that these disclosures are not misleading, given the deficiencies in her qualifications to render an expert opinion on whether information presented by a health care provider in a clinical setting is misleading to patients. Trial Tr. vol. VI (AM), 93:10-19, 116:17-20 (Condic) (no training in communicating with patients in a clinical context); see also *id.* at 111:10-16 (Condic) (acknowledging that "the general way people use" terms may not align with scientific definitions). Dr. Condic purported to hold her opinion that there is nothing misleading about the disclosure that "abortion will terminate the life of a whole, separate, unique, living human being" to "a very high level of scientific certainty," despite acknowledging that the status of an embryo is not a purely scientific question. *Id.* at 74:23-75:10, 82:9-12, 119:19-120:22 (Condic). The level of her conviction expressed on a statement that clearly implicates moral, spiritual, philosophical, and existential beliefs severely undermines her credibility. Furthermore, the Court declines to credit Dr. Condic's opinion that "unborn child" is "a perfectly accurate and reasonable term to use," because this was her "personal opinion" and she could not "testify to the natural usage of the term" because she is "not a linguist." *Id.* at 83:8-23, 115:20-116:8 (Condic).

105. The Court also gives Dr. Condic's opinion about the scientific accuracy of the WRTKA's mandated disclosures about fetal pain little weight. Dr. Condic "do[es] not

work in [the] area" of "human fetal pain" and has never published on the topic. Trial Tr. vol. VI (AM), 94:4-15, 121:18-20 (Condic). Instead, the vast majority of everything she has written on human fetal pain has been testimony in defense of abortion restrictions, including gestational bans on abortion ranging from 20 weeks to 6 weeks LMP. *Id.* at 95:3-96:5 (Condic). Although Dr. Condic testified that her opinions are not influenced by her affiliation with "institutions like the Charlotte Lozier Institute that might be considered pro-life," the Court finds this testimony to be self-serving, inconsistent, and simply not credible. *Id.* at 72:19-74:1, 96:6-100:18 (Condic).

106. Additionally, the Court gives little weight to Dr. Condic's testimony regarding fetal pain because she admitted that her opinions on fetal pain are inconsistent with the positions of major medical and scientific organizations like ACOG, SMFM, the Royal College of Obstetricians & Gynaecologists ("RCOG"), and the International Association for the Study of Pain ("IASP"). Trial Tr. vol. VI (AM); 101:6-102:14, 102:24-104:19, 105:14-17, 106:6-17 (Condic).

107. **Dr. Farr Curlin** is an internal medicine and palliative care physician and holds a joint appointment as a professor of medical humanities at the Duke School of Medicine and the Duke Divinity School. Trial Tr. vol. VI (PM), 10:25-11:13 (Curlin). Dr. Curlin teaches, conducts research, and publishes about medical ethics, in addition to his clinical experience. *Id.* at 9:6-13:23, 16:24-17:15 (Curlin).

108. Dr. Curlin testified that he is critical of "conventional medical ethics," which he defined as "the way medical ethics is characteristically or customarily taught, talked about, and practiced," *id.* at 102:5-9, 101:16-19 (Curlin), particularly because he believes "conventional medical ethics unduly emphasizes patient autonomy." Trial Tr.

vol. VII (AM), 39:7-12 (Curlin). He admitted that his understanding of medical ethics "regarding sexuality and reproduction . . . runs radically counter to conventional medical ethics." Trial Tr. vol. VI (PM), 103:17-22 (Curlin); see, *e.g.*, *id.* at 119:23-123:5 (Curlin) (opining that contraception, in vitro fertilization, and artificial insemination are not medicine and not fully ethical, and that medically assisted gender transition is not medicine and is similar to the use of lobotomies in the twentieth century). Dr. Curlin also disagreed with the "false premise," under conventional medical ethics, that private morality should be "wall[ed] off from professional practice," and testified that "moral" and "ethical are actually synonymous." *Id.* at 135:22-25, 136:13-14, 101:1-3 (Curlin); see also *id.* at 137:9-12 (Curlin) ("[T]he putative distinction between professional and personal opinions is spurious.").

109. Dr. Curlin opined that the WRTKA is ethically justified. Trial Tr. vol. VII (AM), 35:19-36:12 (Curlin). In contrast to Dr. Wynia, whose testimony applied general principles of conventional medical ethics, about which he was qualified to opine, to the WRTKA, Dr. Curlin based his opinions about informed consent in part on his assessment of what he believes a "reasonable abortion patient" would want to know. Trial Tr. vol. VII (AM), 18:20-23 (Curlin). The Court gives little weight to this testimony, as Dr. Curlin has no experience or training in the provision of abortion, has never obtained informed consent for an abortion, has no direct knowledge of how Plaintiffs obtain informed consent, and has never observed a provider obtaining informed consent for an abortion. *Id.* at 18:24-22:2 (Curlin). Nor is that consistent with standards in Kansas for informed consent.

110. Dr. Curlin also testified about APR, including the underlying pharmacological mechanisms and the small body of literature undergirding the APR theory. Trial Tr. vol. VI (PM), 59:22-83:7, 87:21-91:3 (Curlin); Defs.' Ex. 133 (Delgado 2018); Pls.' Ex. 84 (Creinin, Mifepristone Antagonization with Progesterone). Dr. Curlin testified that the 2018 publication led by George Delgado follows a "typical or standard study design," that the authors were "not known to falsify information," and that "there has been no evidence that this study was not presenting evidence as it purports to present it." Trial Tr. vol. VI (PM), 88:1-10 (Curlin); Trial Tr. vol. VII (AM), 28:5-15 (Curlin); cf. Trial Tr. vol. II (AM), 70:15-79:15 (Schreiber). During his direct examination, he did not mention that the Delgado publication had been withdrawn because of an issue related to its IRB approval. See Trial Tr. vol. VII (AM), 28:16-29:20 (Curlin). And while Dr. Curlin testified on direct that the Creinin study provides "evidence suggesting progesterone might be effective in reversing the effects of mifepristone," Trial Tr. vol. VI (PM), 69:17-70:17 (Curlin), he admitted on cross examination that there was no "statistically significant difference" between the hypothesized treatment and the control group from that study. Trial Tr. vol. VII (AM), 26:9-27:8 (Curlin).

111. The Court gives Dr. Curlin's opinions on APR little weight. Dr. Curlin is not an expert in obstetrics and gynecology, his clinical practice has not focused on the treatment of pregnant patients, and he has never prescribed mifepristone or progesterone. Trial Tr. vol. VII (AM), 19:13-20:7 (Curlin). Although Dr. Curlin testified that he is qualified to testify about APR because of his general training as a physician and knowledge derived from recently reviewing clinical research, Trial Tr. vol. VI (PM), 55:14-25 (Curlin), the Court finds his superficial interpretation of such literature to be

self-serving and of little scientific or evidentiary value in this case. See Trial Tr. vol. VII (AM), 23:1-16 (Curlin) (Dr. Curlin is not aware of any area of clinical medicine for which he would not be qualified to interpret literature). The Court credits Dr. Schreiber's testimony, given her specialized relevant training and experience, over Dr. Curlin's testimony about the mechanism of action and biological plausibility of, and limited body of literature regarding, APR. Contrast Trial Tr. vol. II (AM), 64:6-65:24 (Schreiber), with Trial Tr. vol. VI (PM), 54:12-55:25, 59:22-63:15 (Curlin), and Trial Tr. vol. VII, 19:13-20:19 (Curlin).

112. Dr. Curlin also opined that the requirements of the Reason Mandate are ethically justified because they are consistent with features of public health research and that the data collected "can allow the State to take steps to mitigate" particular "health-related challenges." Trial Tr. vol. VI (PM), 83:24-86:19 (Curlin). The sole bases Dr. Curlin offered for his opinions on public health research were his general "train[ing] in health services research," including "how observational studies are done," and his general "aware[ness] of the ethical standards that apply to research generally". *Id.* at 82:15-23. Relatedly, neither his trial testimony nor his CV reveal any additional training, education, or experience related to public health research specifically. *Id.* at 83:18-23 (Curlin); Defs.' Ex. 116 (Curlin CV). Furthermore, Dr. Curlin has no direct knowledge of how the data collected pursuant to the Reason Mandate will be used, whether KDHE plans to implement programs using the data, nor with whom the data will be shared. Trial Tr. vol. VII (AM), 37:15-38:12 (Curlin). Accordingly, the Court finds Dr. Curlin's testimony on the Reason Mandate conclusory and speculative, and the Court, thus, gives it little weight.

113. Finally, Dr. Curlin's testimony is obviously biased and ideologically based. Dr. Curlin testified that his work as an expert witness is motivated, in part, by his "belief that abortion involves the intentional killing of a fetus or embryo." Trial Tr. vol. VII (AM), 41:8-15 (Curlin). Dr. Curlin's bias is also evident from his testimony that women who become pregnant as a result of consensual sex and decide to get an abortion are "blameworthy insofar as she sets out to kill her unborn offspring"; that neutrality on abortion is "the same thing as affirming that abortion is a reasonable medical act"; that when a patient is unable to get an abortion at all because of a waiting period, it is not a worse outcome medically or ethically; and that abortion is not medicine. Trial Tr. vol. VI (PM), 115:21-22, 116:18-24, 132:3-10 (Curlin); Trial Tr. vol. VII (AM), 37:5-12 (Curlin).

114. Although Dr. Curlin maintained that his personal and religious beliefs are "entirely consistent with a proper understanding of medical ethics," the Court finds that this testimony is self-serving and not credible, in light of his admission that he selectively phrased his sworn testimony to make it more difficult to characterize him as an extremist. Trial Tr. vol. VI (PM), 98:11-14 (Curlin). This admission is consistent with Dr. Curlin's presentation and testimony at trial, during which the Court observed that he repeatedly evaded answering Plaintiffs' counsel's questions. *E.g.*, Trial Tr. vol. VI (PM), 104:9-24 (Curlin) (initially denied searching for documents reflective of mainstream bioethicist views, and when probed admitted "now that I think about it, of course I did"); *id.* at 105:7-109:9 (evasive as to whether abortion is ethically permissible in cases of rape); *id.* at 110:3-112:1 (evasive as to his beliefs regarding the "blameworthiness" of women seeking elective abortions stemming from elective sexual intercourse); Trial Tr. vol. VII (AM), 24:24-25:24 (back and forth over statistical significance); *id.* at 31:16-33:8

(only answering whether, absent the WRTKA's provisions, the standard of care required a 24-hour waiting period during the third time it was asked). The Court is also troubled by Dr. Curlin's offering sworn testimony that any inconsistency between Dr. Curlin's personal beliefs and medical ethics "is a reflection of a corruption of medical ethics," Trial Tr. vol. VI (PM), 139:1-3, 144:9-10 (Curlin), and that Dr. Wynia's differences of opinion make him culpable of malpractice, Trial Tr. vol. VII (AM), 38:25-39:3 (Curlin).

115. Given all of the foregoing and after thorough consideration, the Court affords Dr. Curlin's testimony no weight whatsoever. His clear and obvious bias was on display throughout his testimony. His tone and constant avoidance of direct questions on cross examination, as well as his overall demeanor throughout his testimony, seriously undermined any suggestion that he is a neutral, impartial, and objective witness, in this Court's view. He is not. Indeed, his cross examination demonstrated his advocacy and his role as an active and frequent testifying expert in support of restrictive abortion laws, all across our country, despite his acknowledgment that his views on medical ethics do not conform to conventional medical ethics. They are clearly a fringe minority view of ethical standards that are directly attributable to his strong moral and spiritual beliefs on healthcare. As such, his testimony was simply of no credible value.

Obtaining an Abortion/Providing an Abortion.

116. Plaintiff Hodes & Nauser follow the applicable professional standards of care in the field of obstetrics and gynecology. Trial Tr. vol. I (AM), 23:12-14, 23:18-24:1, 27:11-22 (Nauser).

117. In addition to the applicable professional standards of care, Plaintiff Comprehensive Health follows Planned Parenthood Federation of America's Medical Standards and Guidelines, which are developed using the best available medical evidence and reviewed by physicians. Trial Tr. vol. I (PM), 61:18-62:9, 69:5-8 (Alsaden).

118. In addition to the common law doctrine of informed consent, supra FOF ¶¶ 5, 6, 7, common principles of medical ethics, a set of standards established by the medical profession that governs values and conduct in medical practice, require physicians to engage in an informed consent process. Trial Tr. vol. IV (AM), 96:23-97:1, 107:2-108:4 (Wynia). Medical ethicists generally rely on four core principles of medical ethics—autonomy, beneficence, non-maleficence, and justice—as important considerations when managing an ethical issue in medical practice. Trial Tr. vol. IV (AM), 96:23-97:1, 107:2-108:4 (Wynia).

119. The medical-ethical requirement to obtain informed consent prior to treatment derives from the principle of autonomy. Trial Tr. vol. IV (AM), 109:4-15; 111: 23-112:7 (Wynia). It requires physicians to exchange information about a proposed intervention's reasonably anticipated risks, benefits, and alternatives—including the possibility of forgoing treatment—with the patient and to come to a decision with the patient about whether to move forward with the proposed intervention. Trial Tr. vol. IV (AM), 111:16-112:10 (Wynia); Trial Tr. vol. VI (PM), 17:19-18:21 (Curlin); Pls.' Ex. 86 (AMA, Code of Medical Ethics 2.1.1); Pls.' Ex. 110 (ACOG, Informed Consent); see also Trial Tr. vol. VI (PM), 30:4-24 (Curlin).

120. Within these parameters, physicians have the discretion, based upon their professional judgment, to determine what specific risks, benefits, and alternatives to

discuss with a specific patient. Trial Tr. vol. II (PM), 104:19-105:16 (Sawicki); Trial Tr. vol. I (AM), 29:10-30:5 (Nauser); Trial Tr. vol. I (PM), 75:4-11 (Alsaden); Trial Tr. vol. V (PM), 101:21-102:4 (Wubbenhorst); Trial Tr. vol. VII (AM), 30:24-31:12 (Curlin).

121. To determine what information is medically material to the informed consent process for a proposed intervention, physicians may, and generally/commonly do, rely on standards from specialty medical societies or similar professional organizations like ACOG. Trial Tr. vol. IV (AM), 116:14-116:17 (Wynia); Trial Tr. vol. VII (AM), 31:16-24 (Curlin).

122. Physicians must also present information "sensitively, in keeping with the patient's preferences for receiving medical information," which involves tailoring the informed consent process to each individual patient based on their values, preferences, and goals. Pls.' Ex. 86 (AMA, Code of Medical Ethics 2.1.1); Trial Tr. vol. IV (AM), 114:25-115:21 (Wynia); Trial Tr. vol. II (PM), 58:16-59:8, 104:19-105:16 (Sawicki).

123. Obtaining informed consent requires open and effective communication between the patient and the physician, which necessitates developing and maintaining a relationship of trust. Trial Tr. vol. IV (AM), 113:4-18 (Wynia); Pls.' Ex. 86 (AMA, Code of Medical Ethics 2.1.1); Pls.' Ex. 110 (ACOG, Informed Consent).

124. While it may be appropriate for a physician to provide a patient with the professional opinion that a proposed treatment is the best medical option, it is not ethically appropriate for a physician to take a directive approach to the informed consent process for a preference-sensitive decision—i.e., a decision that is values-based—such

as whether to continue or terminate a pregnancy. Trial Tr. vol. IV (AM), 118:20-119:11 (Wynia).

125. In accordance with common law, their medical-ethical obligations, and the applicable standard of care, see FOF ¶¶ 5, 116-124, Plaintiffs discharge their duty to obtain informed consent prior to providing any medical service by disclosing medically material information on the proposed treatment's risks, benefits, and alternatives, giving patients ample opportunity to ask questions, and answering any questions patients have. See, *e.g.*, Trial Tr. vol. I (AM), 28:9-29:19, 30:10-13 (Nauser); Trial Tr. vol. I (PM), 66:21-67:20, 71:18-76:1 (Alsaden); Trial Tr. vol. IV (AM), 111:16-22 (Wynia); Trial Tr. vol. IV (PM), 17:17-18:23 (Wynia); Pls.' Ex. 86 (AMA, Code of Medical Ethics 2.1.1); Pls.' Ex. 110 (ACOG, Informed Consent).

126. Consistent with Kansas's bans on abortion at 22 weeks LMP (K.S.A. 65-6724), and when the fetus is "viable" (K.S.A. 65-6703), Plaintiffs provide abortion care up to 21 weeks 6 days LMP. Trial Tr. vol. I (AM), 33:25-34:12 (Nauser); Trial Tr. vol. I (PM), 62:24-25 (Alsaden). Since legalization, most abortions, in Kansas and nationwide, occur during this timeframe. See Plfs' Ex. 68; pg. 5; Plfs' Ex. 69, pg. 1; see also KDHE, Abortions in Kansas, Preliminary Report 2022, pg. 5 (judicial notice) at https://www.kdhe.ks.gov/DocumentCenter/View/29328/KS-Abortions-2022-PDF?bidId= (last visited 7/30/26).

127. Thus, abortion is time-sensitive health care. Trial Tr. vol. I (AM), 42:6-11 (Nauser); Trial Tr. vol. I (PM), 65:7-13 (Alsaden).

128. Plaintiffs provide two methods of abortion: medication abortion and procedural abortion. Trial Tr. vol. I (AM), 34:13-17 (Nauser); Trial Tr. vol. I (PM), 60:18-19 (Alsaden).

129. Plaintiffs provide medication abortion using a two-drug regimen: 200 mg of mifepristone, followed 24 to 48 hours later by 800 mcg of misoprostol. Trial Tr. vol. I (AM), 34:18-25 (Nauser). This two-medication process is the most common method of medication abortion, and it constitutes safe standard of care treatment for such abortions. See generally Plfs' Ex. 68, 69.

130. Consistent with professional guidelines from organizations like the World Health Organization, CWH offers medication abortion up to 10 weeks LMP and Comprehensive Health up to 12 weeks LMP. Trial Tr. vol. I (AM), 35:1-3 (Nauser); Trial Tr. vol. I (PM), 61:1-16 (Alsaden).

131. Mifepristone stops the pregnancy from continuing and progressing by binding to progesterone receptors and causing the pregnancy tissue and uterine lining to break down and separate from the uterine wall. Trial Tr. vol II (AM), 60:21-61:15 (Schreiber). Mifepristone works "[w]ithin an hour or two." *Id.* at 61:16-17 (Schreiber).

132. Research demonstrates that, by itself, mifepristone is effective in terminating a pregnancy most, but not all, of the time. Trial Tr. vol II (AM), 62:3-21, 100:24-101:1 (Schreiber).

133. Misoprostol causes the cervix to open and the uterus to cramp and contract. Trial Tr. vol II (AM), 61:18-62:2 (Schreiber). Misoprostol works in conjunction with mifepristone to expel the pregnancy from the uterus. *Id.*

134. Many years ago, the FDA approved the use of mifepristone for medication abortion in conjunction with misoprostol. See Trial Tr. vol II (AM), 60:3-6, 63:9-13 (Schreiber).

135. Together, the two medications are effective at terminating an early pregnancy in nearly all cases. Trial Tr. vol. I (AM), 35:4-7 (Nauser); Trial Tr. vol II (AM), 60:13-16 (Schreiber).

136. Medication abortion is safe and has a major complication rate below one percent. Trial Tr. vol. I (AM), 36:12-25 (Nauser); Pls.' Ex. 68, at 55 (NASEM, The Safety and Quality of Abortion Care in the U.S.). Indeed, the reported risks and complication rates for a medication abortion are low and are similar in magnitude to the reported risks of serious adverse effects of commonly used prescription and over-the-counter medications. See Plfs' Ex. 68, at 58.

137. The same medications used for medication abortion are offered to treat patients who have a miscarriage with retained tissue. Trial Tr. vol. I (AM), 35:14-22 (Nauser); accord Trial Tr. vol. V (PM), 119:25-120:7 (Wubbenhorst).

138. Procedural abortions are performed by dilating the cervix and using suction and/or instruments to empty the uterine contents. Trial Tr. vol. I (AM), 39:8-12, 39:16-40:4 (Nauser).

139. Procedural abortion is exceedingly safe, but the risks of such a procedure increase later in pregnancy (beyond the times generally permitted in Kansas). Trial Tr. vol. I (AM), 40:23-41:24 (Nauser).

140. The same procedural techniques used in abortion care are also used in miscarriage management. Trial Tr. vol. I (AM), 40:10-16 (Nauser); accord Trial Tr. vol. V (PM), 119:25-120:7 (Wubbenhorst).

141. The risks of these procedures are the same regardless of whether they are used for abortion or other care, such as miscarriage management. Trial Tr. vol. I (AM), 41:25-42:5 (Nauser).

142. Although abortion is exceedingly safe, complications can and do occur, as with all medical interventions, and the risk of complications increases later in gestation. Trial Tr. vol. I (PM), 63:1-5, 64:25-65-13 (Alsaden).

143. Abortion is no exception to the requirement to obtain informed consent. Absent the WRTKA, when obtaining informed consent to abortion, Plaintiffs provide patients with medically material information about the proposed abortion method's risks, benefits, and alternatives, field patients' questions, and confirm whether the patient wants to proceed. Trial Tr. vol. I (AM), 35:23-36:11, 42:12-43:13, 44:10-19, 45:6-12, 46:3-21 (Nauser); Trial Tr. vol. I (PM), 30:18-33:24, 34:8-14 (Nauser); *id.* at 66:18-20 (Alsaden); Trial Tr. vol. II (PM), 121:6-23 (Wales); Pls.' Ex. 48 (CWH website "Pregnancy Termination/Abortion"); Pls.' Ex. 45 (PP-0002827); Pls.' Ex. 43 (PP-0001354); Pls.' Ex. 49 (PP-0000449). This is consistent with the legal and professional standard of care.

144. The risks of medication abortion include failure, heavy bleeding, and in very rare instances, infection, and death. Trial Tr. vol. I (AM), 36: 12-22 (Nauser); Pls.' Ex. 50 (PP-0000421 Part I & II). Patients may also experience elevated body temperatures, funny tastes, irritation, diarrhea, shivering/shaking like they are cold,

bleeding, and cramping. Trial Tr. vol. I (AM), 36:3-11 (Nauser); Pls.' Ex. 50 (patients may experience headaches, dizziness, backpain, and tiredness after taking misoprostol).

145. Patients considering procedural abortions are also informed of the special risks associated with the procedure, such as potential injury to the uterus resulting from use of surgical tools and risks associated with sedation. See generally Pls.' Ex. 49 (PP-0000449).

146. Plaintiffs "try and make things as comfortable for the patients as [possible] once they're in the building" and "make sure the patients understand anything they say . . . to me is between me and the patient and the chart." Trial Tr. vol. I (AM), 25:20-22, 26:16-17 (Nauser).

147. When people call to schedule an abortion at CWH, staff direct them to review the information on the "abortion" page of CWH's website and in the consent packet for the elected abortion method. Trial Tr. vol. I (AM), 42:12-43:4 (Nauser). Patients who do not bring the consent packet to their appointment are provided with it at check-in. *Id.*; *id.* at 44:10-16 (Nauser). Patients then receive an ultrasound and meet with Dr. Nauser, who discusses the proposed abortion method with the patient, answers any questions, and obtains informed consent. *Id.* at 28:12-29:9, 42:12-43:4 (Nauser).

148. At Comprehensive Health, abortion patients are provided with printed educational materials and an iPad with educational videos about the elected abortion method upon check-in. Trial Tr. vol. I (PM), 69:12-19 (Alsaden); Pls.' Ex. 49 (PP-0000449); Pls.' Ex. 50 (PP-0000421); Defs.' Ex. 61a (PP-0008189); Defs.' Ex. 62a (PP-0008191). Patients then receive an ultrasound and meet with a patient educator, who

orally reviews the content of the educational materials and videos with patients, reviews the informed consent documents specifically, gives patients ample opportunity to ask questions, and obtains informed consent. Trial Tr. vol. I (PM), 69:9-71:1, 71:7-15, 72:7-74:10 (Alsaden); Pls.' Ex. 49 (PP-0000449); Pls.' Ex. 50 (PP-0000421). Patients also meet with their abortion provider before the abortion. Trial Tr. vol. I (PM), 70:11-14 (Alsaden).

149. While the educational materials Plaintiffs provide to patients are standardized, their process for obtaining informed consent is always tailored to the individual patient's clinical presentation and personal preferences. Trial Tr. vol. I (AM), 29:16-19, 29:23-30:5 (Nauser); Trial Tr. vol. I (PM), 34:15-21 (Nauser); *id.* at 75:4-11, 75:15-19, 76:2-12, 76:13-77:3 (Alsaden).

150. To create the safety necessary for patients to entrust Plaintiffs with sensitive information about their health, bodies, families, and lives, Plaintiffs respect patients' privacy and approach communication with sensitivity. Trial Tr. vol. I (AM), 24:11-25:7, 25:15-26:2 (Nauser); Trial Tr. vol. III (AM), 12:11-18 (Wales). That includes using terminology that is comprehensible, paying attention and responding to patients' body language and cues, and mirroring the language that patients use to refer to their pregnancies. Trial Tr. vol. I (AM), 33:11-19, 92:18-24 (Nauser).

151. And although Plaintiffs do not generally ask patients to divulge information that is not clinically or operationally necessary, the considerations involved in patients' medical decision-making sometimes come up in discussion. Trial Tr. vol. I (AM), 49:18-50:23 (Nauser) ("It's not my business why they're there. My job is to provide a service in

a nonjudgmental patient-centered way."); Trial Tr. vol. I (PM), 36:24-37:4 (Nauser); *id.* at 101:10-15 (Alsaden).

152. Consistent with the professional standard of care, Plaintiffs use a patient-centered approach to discuss pregnancy options, assess whether a patient's decision to obtain an abortion is voluntary and uncoerced, and, when appropriate, address sensitive topics like patients' experiences of domestic and sexual violence. See Trial Tr. vol. I (AM), 23:12-14, 32:11-33:10, 56:14-57:13 (Nauser); Trial Tr. vol. I (PM), 26:4-23, 27:20-28:18 (Nauser); *id.* at 75:15-19, 76:2-12 (Alsaden).

153. For instance, when a pregnant patient wants to discuss the options that are available, Dr. Nauser provides pregnancy options counseling. She begins by asking—and discerning based on the patient's body language and demeanor—how the patient feels about the pregnancy and follows the patient's lead "down an avenue of discussion" "based on whatever they say." Trial Tr. vol. I (AM), 31:23-32:19 (Nauser). If the patient is "unsure" or does not know how they want to proceed, Dr. Nauser "ha[s] a conversation with her about sitting down by herself when she's writing down a list of pros and cons" for each pregnancy option—staying pregnant and having a baby, staying pregnant and pursuing adoption, and terminating the pregnancy—starting with "just the facts with no emotions in each column." *Id.* at 31:23-33:3 (Nauser). Once the patient has determined which column has the most pros, the next step is to "put the emotion [into] it and decide if that's something that she can live with, close [her] eyes and go to sleep at night and know that she made the right decision." *Id.* at 33:3-7 (Nauser). If that option is not, then the patient "mark[s] that one off, [and] go[es] back to the last two columns" to find the "answer that [she] can live with." *Id.*

154. Plaintiffs screen patients to ensure that they are certain about their decision and that their decision is voluntary. Trial Tr. vol. I (PM), 27:20-24 (Nauser); *id.* at 75:12-76-3 (Alsaden). For instance, prior to providing an abortion, Dr. Nauser always asks patients whether "they're sure about their decision," and "[i]f there's any hesitancy" from the patient or "cues" that the patient is less than certain, Dr. Nauser "will not proceed" and instead provides pregnancy options counseling to the patient. *Id.* at 46:3-21 (Nauser). No patient has ever told Dr. Nauser that they no longer wish to terminate their pregnancy after taking mifepristone, "because during the consenting process, I make sure that they're sure before I give them the mifepristone." *Id.* at 120:14-19 (Nauser).

155. Comprehensive Health also asks patients screening questions to ensure that patients' decisions are voluntary and uncoerced, and to screen for domestic violence. Trial Tr. vol. I (PM), 75:15-19 (Alsaden). Staff are trained to identify coercion, and to take measures to ensure the immediate safety of, and to offer resources to, patients who are subject to domestic violence. *Id.* at 75:15-19, 76:2-12, 104:11-22 (Alsaden).

156. Plaintiffs have not and would not provide an abortion without confirming that the patient is certain in their decision and that it is voluntary. Trial Tr. vol. I (AM), 46:7-21 (Nauser); Trial Tr. vol. I (PM), 76:13-77:3 (Alsaden).

157. Plaintiffs have never been disciplined or investigated by BOHA for alleged failure to obtain informed consent. Trial Tr. vol. I (AM), 30:25-31:7, 31:12-17 (Nauser); Trial Tr. vol. II (PM), 121:24-122:7 (Wales). Plaintiffs' physicians have never been sued for alleged failure to obtain informed consent for any treatment provided by Plaintiffs. *Id.*

at 31:8-11, 31:18-22 (Nauser); Trial Tr. vol. II (PM), 121:24-122:7 (Wales). However, like other health care providers, Comprehensive Health occasionally receives patient complaints and takes them seriously, investigating them and implementing corrective actions as needed. See Trial Tr. vol. III (AM), 76:8-95:6 (Wales); *id.* at 96:7-19, 98:18-99:11 (Wales).

158. As it relates to the WRTKA, including the APR Mandate, there is no evidence that was presented at trial to reflect any significant health-related or safety-related problem for pregnant women that existed at the time of promulgation and was contemporaneously considered by the Legislature in an attempt to address that problem. Indeed, that was the case as it relates to any of the provisions, no matter when enacted.

159. There is no credible evidence that coercion is more prevalent among patients seeking abortion than those seeking other forms of reproductive health care. In support of her opinion that there is a high rate of coerced abortion, Dr. Wubbenhorst relied on a study that reported a significant percentage of pregnant women seeking abortion report a history of abuse and that they are more likely to make the abortion decision without partner involvement. Contrast Trial Tr. vol. V (PM), 14:3-14 (Wubbenhorst) (stating coercion factors into informed consent to abortion because many abortions are coerced, relying on Glander), with Defs.' Ex. 169, at 1002, 1005 (Glander) (reporting on prevalence of abuse by pregnant women seeking abortion—not prevalence of coerced abortion—and stating "some abused women may attempt to reclaim control by eliminating the partner from the abortion decision"). Dr.

Wubbenhorst's extrapolations are not credible evidence to support her conclusion—to the extent they are supportive at all.

160. Patients may feel a variety or combination of emotions after an abortion. Trial Tr. vol. VII (PM), 9:13-11:2 (Kimport); Trial Tr. vol. I (PM), 73:2-6 (Alsaden); Pls.' Ex. 49, at 19 (PP-0000449); Pls.' Ex. 48, at 3 (CWH website "Pregnancy Termination/Abortion"). Scientifically valid research demonstrates that "the vast majority" of "people feel positive emotions following [an] abortion"; though some people may experience negative emotions (including regret) or a combination of negative and positive emotions, "over time, the rate of experiencing negative emotions actually decreases and the research has found no evidence that negative emotions emerge over time in terms of feelings about the abortion and the [abortion] experience." Trial Tr. vol. VII (PM), 9:13-10:13 (Kimport).

161. Scientifically valid research also shows that "even among the people who would report negative emotions including regret, 95 percent of them will still report that they felt that the abortion was the right decision." *Id.* at 10:24-11:2 (Kimport); accord Trial Tr. vol. I (AM), 109:4-8, 128:15-17 (Nauser) (no patient has ever told Dr. Nauser that they regretted their abortion).

162. Dr. Nauser is herself intimately familiar with the feelings patients may have about getting an abortion, as she is "personally one of those patients" who was sad about having to get an abortion and the circumstances surrounding her abortion; but she did not regret the abortion or ever question if it "was the right thing to do," and "would make that same decision today if put in the same situation." Trial Tr. vol. I (AM), 109:9-112:5 (Nauser) ("I wouldn't have my children that I have today [if not for the

abortion], and I cannot imagine life without them."); see also Trial Tr. vol. I (PM), 40:18-21 (Nauser) ("Grie[f] and regret are two different things.").

163. For the small number of patients who report experiencing regret about their abortions, research shows that this is "largely due to their social circumstances, experiences of [social] disapproval, [and] the way that people interacted with them about their decision to have an abortion." Trial Tr. vol. VII (PM), 21:21-22:9 (Kimport).

Hurdles to Receiving/Providing Care.

164. More patients are traveling from states that ban abortion—like Texas, Oklahoma, Louisiana, and Arkansas—to seek care in Kansas. Trial Tr. vol. I (AM), 47:1-9 (Nauser); Trial Tr. vol. I (PM), 21:12-16, 25:2-9 (Nauser); Trial Tr. vol. IV (AM), 89:7-24 (Huntington), Trial Tr. vol. II (PM), 115:8-15, 117:4-10 (Wales).

165. This influx of people from other states seeking abortion in Kansas has made it more difficult for Kansans to get appointments and has delayed their care. Trial Tr. vol. I (PM), 66:10-17 (Alsaden); Trial Tr. vol. II (PM), 115:16-24, 117:21-118:2 (Wales).

166. A significant number of Plaintiffs' patients face barriers in accessing abortion care, such as inability to take time off from work, find childcare, and/or raise the funds to cover the costs of travel, childcare, and/or lodging. Trial Tr. vol. I (AM), 47:12-17, 48:16-49:6 (Nauser); Trial Tr. vol. I (PM), 65:14-22 (Alsaden); Trial Tr. vol. IV (AM), 34:3-18 (Huntington).

167. Safety and privacy risks such as fear that the decision to obtain abortion will be discovered by an abusive or unsupportive partner or family member, and

harassment by anti-abortion protesters or other members of the public, are additional barriers to accessing and providing abortion care. Trial Tr. vol. I (AM), 26:3-17 (Nauser) ("[CWH] ha[s] picketers that are outside."); Trial Tr. vol. I (PM), 63:16-22 (Alsaden).

168. Abortion patients and providers also face stigma. Trial Tr. vol. I (AM), 26:3-11 (Nauser) ("There's a lot of stigma, shame, associated with potentially having an abortion or having an abortion."); Trial Tr. vol. (PM), 65: 1-21; 79:12-80:11 (Syrett) (19th and 20th century women seeking abortions viewed as blameworthy and/or selfish and their reasons for seeking abortions often belittled); *Id.* at 98:18-99:1 (Syrett) (the stigmas of the past shape the present); *Id.* at 150:22-151:2 (Hoyle) (felt shame for having an abortion).

169. Stigma is the negative social valuing of a group of people because of an identity or behavior that discredits them, labeling them as abnormal or deviant from the broader community in a negative way. Trial Tr. vol. III (AM), 123:25-124:17 (Kimport). The process of creating a discredited identity or behavior is known as stigmatization. *Id.* at 124:10-12 (Kimport).

170. Laws that single out abortion for regulation and that are medically unnecessary or have no measurable benefit to patient health of safety outcomes stigmatize abortion. *Id.* at 125:10-24 (Kimport).

171. Stigmatization can increase abortion patients' experiences of shame and isolation and broadly increase their experiences of negative emotional or mental health outcomes. *Id.* at 128:3-8 (Kimport).

172. The politicization and stigmatization of abortion in Kansas have also made it difficult, in the past, for Comprehensive Health to recruit local physicians to provide abortion care and led Comprehensive Health to employ contract physicians from outside the region. Trial Tr. vol. I (PM), 63:11-22 (Alsaden).

173. Nevertheless, Plaintiffs devote significant time and resources to helping patients mitigate barriers to care. For instance, CWH coordinates with abortion funds to assist patients who cannot pay for the abortion and/or associated costs. Trial Tr. vol. I (AM), 47:12-17 (Nauser); Pls.' Ex. 34 (CWH-0008450-52); Pls.' Ex. 35 (CWH-0008456). So does Comprehensive Health, as part of its patient navigation assistance program, which also assists with making travel arrangements and booking accommodations. Trial Tr. vol. IV (AM), 33:21-34:2, 37:6-18, 64:2-5 (Huntington).

Subject Laws' Impact on Providing Care – Delaying or Denying Care.

174. The WRTKA delays and results in denials of abortion care. It significantly impairs the providers' ability to provide such medical services and patients' ability to receive them. See FOF ¶¶ 174-186.

175. Prior to the Temporary Injunction, ensuring compliance with the Act's requirements affected every aspect of Plaintiffs' provision of abortion care, complicated Plaintiffs' operations, consumed their limited resources and staff time, demoralized staff, and resulted in delays—or even denials—of abortion care for patients. Trial Tr. vol. I (AM), 108:3-10 (Nauser); Trial Tr. vol. I (PM), 42:7-18, 43:20-44:5 (Nauser); *id.* at 79:9-13 (Alsaden); Trial Tr. vol. II (AM), 48:8-49:13 (Alsaden); Trial Tr. vol. II (PM), 111:8-15, 128:13-129:14, 141:20-142:11 (Wales); Trial Tr. vol. IV (AM), 38:9-13, 39:16-40:4, 83:4-

12, 41:2-12, 50:16-24, 77:6-10 (Huntington); *id.* at 20:17-21:2, 24:2-12, 24:17-25:1 (Ranney); Trial Tr. vol. II (PM), 134:4-136:1 (Wales) (K.S.A. 65-6709(a)(1)'s physician details requirement created privacy and security risks to providers, who were leery of potential violence due to "the history" in Kansas where "the murder of Dr. Tiller weighs on everyone's minds.").

176. Patients were forced to wait at least 24 hours after receiving the mandated disclosures, even if Plaintiffs could otherwise schedule them sooner and even if they wished to proceed. Trial Tr. vol. I (AM), 64:16-65:2, 66:5-10, 71:5-72:2, 78:4-9 (Nauser); Trial Tr. vol. I (PM), 127:19-24, 128:13-18 (Alsaden); Trial Tr. vol. II (AM), 48:18-49:13 (Alsaden); Defs.' Ex. 115 (PP-0004934); Trial Tr. vol. IV (AM), 38:9-13, 39:16-40:4, 41:2-12, 50:16-24 (Huntington).

177. Post-abortion follow-up care was also delayed because of the WRTKA. Trial Tr. vol. II (AM), 42:3-44:17 (Alsaden); Defs.' Ex. 115 (PP-0004934) (email exchange reflecting that because there was still fetal cardiac activity after a procedural abortion, the WRTKA's 24-hour requirement delayed patient's follow-up care).

178. The requirements that the "physician who is to perform the abortion" meet with the patient and offer them "the opportunity to view the ultrasound image at least 30 minutes prior" to the abortion are medically unnecessary, limited the number of patients that Plaintiffs could serve, and forced Plaintiffs to alter their patient flow and Comprehensive Health to even modify its building space with an otherwise "useless space in the middle of the health center." Trial Tr. vol. II (PM), 122:14-123:21 (Wales); see also Trial Tr. vol. I (AM), 98:18-100:11, 101:3-18 (Nauser); Trial Tr. vol. I (PM), 85:4-

86:20, 87:8-13 (Alsaden); Trial Tr. vol. III (AM), 17:9-19:10 (Wales); Trial Tr. vol. IV (AM), 18:4-16 (Ranney).

179. The WRTKA forced Plaintiffs to implement time-consuming protocols to ensure compliance with the requirement that mandated disclosures be provided in "printed" form in accordance with precise typeface, font size, and color ink and paper requirements: to avoid additional delay to patients that would result from mailing the consent packets or requiring patients to pick them up in-person at least 24 hours prior to their abortion, as well as the privacy and security risks of mail being intercepted, Plaintiffs instructed patients in painstaking detail—spending "[a]t least 15 minutes" per patient—on how to print in the Act's mandated format, sign, and date the forms at least 24 hours prior to their appointment. Trial Tr. vol. I (AM), 61:20-62:19, 76:19-77:12 (Nauser); Trial Tr. vol. II (AM), 17:4-13 (Alsaden); Trial Tr. vol. II (PM), 136:13-14, 138:23-139:7 (Wales); Trial Tr. vol. IV (AM), 38:14-21, 39:6-10 (Huntington); *id.* at 13:2-18, 14:2-7 (Ranney); see *id.* at 28:11-14 (Ranney) (mailing forms delayed scheduling abortion by four to five days).

180. Comprehensive Health sent patients multiple reminders by email, phone call, and text, and posted the materials required by the WRTKA conspicuously on the home page of its website. Trial Tr. vol. II (PM), 129:5-6, 129:9-14, 131:6-17, 137:13-138:10 (Wales); Trial Tr. vol. IV (AM), 38:14-19, 39:6-10 (Huntington). Once patients arrived for their appointment, Comprehensive Health had a "multistep process" to ensure that consent forms met the statutory requirements because of the "serious" risks of "being wrong": Comprehensive Health "not only had the front desk staff[,]who were trained to review[,] initially" check, but also had "the patient educators do a secondary

check, [and] the provider would also check for themselves." Trial Tr. vol. II (PM), 129:15-130:17, 142:12-144:1 (Wales). If there were any questions or concerns, the manager, vice president, general counsel, or even Ms. Wales in her role as CEO, would be brought in to review the forms for compliance. *Id.*

181. Similarly, prior to patients' appointments, CWH offered to check scans of patients' printed consent packets to confirm whether they conformed with the Act's requirements. Trial Tr. vol. I (AM), 65:16-66:4 (Nauser); Trial Tr. vol. IV (AM), 11:20-23 (Ranney). Once patients arrived for their appointment, CWH staff would compare each page of the consent packet to a "laminated" "master copy," going "pretty much line by line [to] make sure that the consents are proper there on white paper with black ink in size 12 New Times Roman font," which would take "at least 30 minutes." Trial Tr. vol. IV (AM), 15:16-22, 16:1-7 (Ranney); Trial Tr. vol. I (AM), 61:20-62:19, 65:3-10 (Nauser). Prior to the Temporary Injunction, Ms. Ranney would spend about seven hours in a typical workday processing WRTKA paperwork. Trial Tr. vol. IV (AM), 24:9-12 (Ranney).

182. Plaintiffs also spent significant time and/or expense developing, updating, and training staff on policies and procedures for compliance with the WRTKA; updating and translating the mandated disclosures whenever the physician details required by K.S.A. 65-6709(a)(1) changed or the Act was amended; and making and posting obtrusive four-foot long signs with lettering in the requisite size and "boldfaced type." K.S.A. 65-6709(k); see Trial Tr. vol. II (PM), 124:14-125:10, 128:19-129:4, 129:5-10, 132:4-133:22, 140:1-15, 140:16-141:19 (Wales); Pls.' Ex. 54 (CWH-0003094); Pls.' Ex. 19 (CWH-0001694); Pls.' Ex. 28 (CWH-0001399); see also Trial Tr. vol. I (AM), 64:4-15, 102:3-103:1 (Nauser).

183. Despite the significant lengths to which Plaintiffs went to assist patients with the onerous paperwork requirements, if patients' forms did not meet the WRTKA's specifications, Plaintiffs were forced to turn them away. Trial Tr. vol. I (AM), 70:6-13 (Nauser); Trial Tr. vol. I (PM), 79:9-13 (Alsaden); Trial Tr. vol. III (AM), 9:9-17 (Wales); Trial Tr. vol. IV (AM), 76:6-10 (Huntington); *id.* at 16:4-7, 18:25-19:8 (Ranney); Pls.' Ex. 34 (CWH-0008450) (Oklahoma resident was turned due to the WRTKA after traveling for six hours to CWH); Pls.' Ex. 35 (CWH-0008456) (Texas resident whose pregnancy was the result of rape was turned away twice, first due to paperwork issues, and the second time because her pregnancy measured too far for CWH to provide care); Pls.' Ex. 45 (PP-0002827).

184. Paperwork compliance issues forced CWH to turn away approximately ten patients per week, and Comprehensive Health had to turn away approximately five to ten patients a week at just its Overland Park location, with up to potentially five or six patients getting turned away a day from each of its Kansas locations. Trial Tr. vol. I (AM), 70:6-11 (Nauser); Trial Tr. vol. IV (AM), 17:9-12, 20:3-6 (Ranney); *id.* at 77:6-10 (Huntington); Trial Tr. vol. I (PM), 79:9-13 (Alsaden); Trial Tr. vol. III (AM), 13:11-19 (Wales).

185. The precise timing and formatting specifications of the WRTKA impacted many of Plaintiff's patients (including nearly half of CWH's patients) by delaying and burdening their care, particularly if they could not access a printer or pick up a hard copy from Plaintiffs; printed the wrong documents, such as the KDHE booklet or outdated versions of consent packets that had been posted to anti-abortion websites; forgot to bring their printed documents to their appointment; lost their printed documents

in transit, or brought to their appointment documents that were dated less than 24 hours before their appointment or printed incorrectly (e.g., on pink paper). Trial Tr. vol. I (AM), 66:24-67:16, 70:6-11, 76:10-12 (Nauser); Trial Tr. vol. I (PM), 79:14-80:2 (Alsaden); *id.* at 83:10-22 (Alsaden) (Comprehensive Health organized a ride share to a library for a minor patient who could not access a printer); Trial Tr. vol. III (AM), 7:23-9:17 (Wales); Trial Tr. vol. IV (AM), 41:2-5, 42:23-43:9, 47:3-19, 50:16-20, 50:25-51:7, 54:18-55:4, 55:14-16, 56:24-59:5 (Huntington); Pls.' Ex. 41 (PP-0001367); Pls.' Ex. 44 (PP-0002757); Trial Tr. vol. IV (AM), 16:8-17:8 (Ranney) (CWH patients brought in "Planned Parenthood consent forms" or KDHE materials).

186. Such denial of care is "ethically problematic" because it "tak[es] . . . [the] decision away from the patient . . . for reasons that are completely unrelated to medicine." Trial Tr. vol. IV (AM), 131:24-132:4 (Wynia).

187. Plaintiffs' patients seeking abortion were often devastated to be turned away. Trial Tr. vol. I (AM), 72:3-21 (Nauser) ("We have emotionally traumatized those patients when we're unable to see them that day."); *id.* at 66:24-67:16, 70:6-11, 76:10-18 (Nauser); Trial Tr. vol. IV (AM), 38:14-39:5 (Huntington) (patients were "audibly upset" and "crying sometimes"); Trial Tr. vol. II (PM), 112:8-10, 113:16-21 (Wales). At least one Comprehensive Health patient said they would commit suicide after being turned away due to the WRTKA. Trial Tr. vol. I (PM), 84:1-4 (Alsaden); Trial Tr. vol. IV (AM), 49:19-50:14 (Huntington); Pls.' Ex. 47 (PP-0003696).

188. Their distress also impacted plaintiffs' staff and other patients, who had to contend with reactions such as crying, screaming, damaging property, and stating that they would kill staff or themselves. Trial Tr. vol. I (AM), 67:8-16 (Nauser) (patient who

was turned away because paperwork was pink "was extremely upset to the point that I could hear it and had to get involved"); see also *id.* at 70:12-25 ("They would be distraught, very upset, confused. They don't understand why it matters what color ink they used, what color paper they have . . . ."); *id.* at 71:5-72:21 (Nauser) ("Police have had to be called to calm the situation down before. It's traumatizing to staff."); *id.* at 75:19-76:9, 108:9-22 (Nauser); Trial Tr. vol. II (PM), 118:7-15, 144:2-145:7 (Wales); Trial Tr. vol. IV (AM), 20:17-21:2, 23:2-7 (Ranney) ("be[ing] the person that says, hey, I know you've got a lot going on, but, sorry, we can't help you" is "so hard," particularly when Ms. Ranney has "had personal life events that [she] could have been" the Texas patient whose pregnancy was the result of rape and who was twice turned away); *id.* at 24:2-12, 24:17-25:1 (Ranney) ("Working at Center for Women's Health with the law in place was so much more stressful than answering 911 calls"); *id.* at 23:13-19 (Ranney) (describing patient who was "so mad, when she flung the front door open, which was all glass, it bounced off the building and shattered everywhere"). For Plaintiffs' staff, whose "entire job" and "entire reason for working in healthcare is to help patients get healthcare in an easy and efficient manner and as emotionally supportive manner as possible," "turn[ing] people away" and "mak[ing] patients cry" is "traumatizing" because it is "doing the opposite." Trial Tr. vol. I (AM), 108:11-22 (Nauser).

189. As a result of the WRTKA—despite Plaintiffs' attempts to reschedule patients who were turned away and to assist with logistics like funding, travel, and lodging—some people who sought abortion in Kansas were denied access to their preferred abortion method or denied access to legal abortion care in Kansas. Trial Tr. vol. I (AM), 66:5-10, 71:22-72:2, 73:21-75:18 (Nauser); Trial Tr. vol. I (PM), 80:3-81:14,

83:5-9 (Alsaden); Trial Tr. vol. II (PM), 129:15-130:5 (Wales); Trial Tr. vol. III (AM), 15:7-24 (Wales); Trial Tr. vol. IV (AM), 19:12-15 (Ranney) ("Some patients didn't have the funding to come back, the transportation or the ability to move their schedule"); *id.* at 18:25-19:10, 20:9-16 (Ranney); *id.* at 16:4-7, 38:4-40:3, 41:2-45:17, 47:3-48:23, 51:14-52:21 (Huntington); Pls.' Ex. 42 (PP-0002754); Pls.' Ex. 43 (PP-0001354); Pls.' Ex. 44 (PP-0002757); Pls.' Ex. 45 (PP-0002827); Pls.' Ex. 47 (PP-0003696). For example, a Texan whose pregnancy was the result of rape was twice turned away from CWH, first because her paperwork did not conform with the WRTKA, and then because her pregnancy was too far along for her to receive care at CWH; she ultimately "did not get to have [an] abortion." Trial Tr. vol. IV (AM), 31:3-9 (Ranney). CWH also had to turn away a woman who sought medication abortion when her pregnancy dated 9 weeks 6 days, which pushed her beyond CWH's gestational limit for medication abortion. Trial Tr. vol. I (AM), 74:13-21 (Nauser). She and her partner became so upset that "both of them were screaming and yelling in the lobby, creating a scene" and refusing to leave, leading CWH to call law enforcement to "escort[] them out of the building." *Id.* at 74:21-75:18 (Nauser).

190. The barriers to accessing abortion imposed by the WRTKA disproportionately impacted Plaintiffs' most vulnerable patients, such as those who traveled a long distance to Plaintiffs' facilities, low-income patients who were more likely to face logistical challenges with bringing printed documents and with rescheduling the appointment if they were turned away, and those with limited English proficiency, who often had difficulty understanding the WRTKA's requirements. Trial Tr. vol. III (AM), 12:19-13:5 (Wales); Trial Tr. vol. IV (AM), 38:9-13, 41:2-12, 42:12-20 (Huntington)

(Comprehensive Health patient who flew to Kansas for her appointment had to stay at a hotel after being turned away due to the WRTKA); *id.* at 48:8-23, 50:16-24 (Huntington); *id.* at 21:25-22:9 (Ranney). Imposing such burdens violates the medical-ethical principle of justice. Trial Tr. vol. IV (AM), 132:18-133:9 (Wynia).

191. Even when the WRTKA did not result in patients being turned away, it interfered with their autonomous decision-making in multiple ways: patients had to wait 24 hours after receiving state-mandated disclosures—including in KDHE-published materials—before their consent to abortion was considered valid. Trial Tr. vol. I (AM), 62:16-63:20 (Nauser); Trial Tr. vol. I (PM), 23:1-13 (Nauser); *id.* at 77:18-24 (Alsaden). At their appointments, patients were shown a giant sign with boldfaced text duplicative of mandated disclosures they already received, Trial Tr. vol. II (PM), 125:14-128:11 (Wales); Trial Tr. vol. IV (AM), 14:11-22 (Ranney); forced to wait "[a]t least 30 minutes"—if not longer—after receiving the mandated offer to view and keep the ultrasound image from and meeting privately with their provider, Trial Tr. vol. I (PM), 85:11-86:7 (Alsaden); and required to certify receipt of the various mandated disclosures and offers before they could finally receive an abortion. K.S.A. 65-6709(e).

192. Since the WRTKA was temporarily enjoined, Plaintiffs are no longer forced to turn patients away due to paperwork issues and have been able to provide care to patients on the day it is scheduled and sought. Trial Tr. vol. I (AM), 78:10-22, 98:18-22, 101:16-18 (Nauser); Trial Tr. vol. I (PM), 23:25-24:10, 35:5-11 (Nauser); *id.* at 84:19-21 (Alsaden); Trial Tr. Vol II (AM), 48:4-49:13 (Alsaden); Trial Tr. vol. III (AM), 114:20-115:7 (Wales); Trial Tr. vol. IV (AM), 61:25-61:8, 62:24-63:5 (Huntington); Trial Tr. vol. VI (AM), 10:22-11:15 (Sandoval).

193. Plaintiffs no longer post or provide information and links required by the WRTKA to their websites and have taken down the obtrusive signs required by the WRTKA. Trial Tr. vol. II (PM), 125:7-13 (Wales); Trial Tr. vol. III (AM), 16:22-17:8 (Wales); Pls.' Ex. 48 (CWH website "Pregnancy Termination/Abortion").

Inaccuracy of Mandatory Disclosures, including on APR Theory.

194. The WRTKA compels abortion providers to convey, through multiple formats, state-mandated messages with which they disagree, including disclosures that fall outside the standard of care for obtaining informed consent to abortion and are medically immaterial to abortion's risks, benefits, and alternatives; that are medically inaccurate; or that are misleading. Trial Tr. vol. I (AM), 87:23-88:14 (Nauser) ("not every patient needs" contact information for perinatal hospice services); *id.* at 91:11-22 (Nauser) (availability of medical assistance benefits for prenatal care, childbirth, and neonatal care is "not medically or clinically relevant"); *id.* at 95:3-96:9 (Nauser) (disclosures about fetal pain are "not true"); *id.* at 85:1-11, 86:6-10, 92:3-13, 92:18-94:2, 94:13-24, 103:24-104:17, 105:11-106:11, 107:3-12, 108:1-8 (Nauser); Trial Tr. vol. I (PM), 5:15-21 (Nauser); *id.* at 88:22-90:5, 93:12-25, 95:21-97:17 (Alsaden); Trial Tr. vol. III (AM), 16:16-21 (Wales); Trial Tr. vol. VII (AM), 106:1-108:11, 108:22-109:6 (Ralston).

195. For example, the credible evidence at trial was that the term "unborn child" is not a medical term. Trial Tr. vol. I (AM), 92:18-24 (Nauser); Trial Tr. vol. I (PM), 133:13-21 (Alsaden); cf. Trial Tr. vol. VI (AM), 83:7-23 (Condic); Trial Tr. vol. VI (PM), 26:25-27:12 (Curlin). And the more credible evidence, through several witnesses—including testimony from the State's expert Dr. Condic—demonstrates that the mandated disclosure that "an abortion terminates the life of a whole, separate, unique,

living human being" is not a medically material "fact." Trial Tr. vol. I (PM), 88:22-90:5 (Alsaden) (disclosure that an "abortion terminates the life of a whole, separate, unique, living human being" is "more of a philosophical or ideological question rather than being based on medical science and facts"); Trial Tr. vol. VI (AM), 119:9-22 (Condic) ("I would not attempt to define a human in a medical dictionary because it's not relevant to the practice of medicine."); *id.* at 120:6-22 (Condic) (acknowledging that the question of the status of an embryo is not purely scientific).

196. The mandated disclosures regarding risk of breast cancer and preterm birth in future pregnancies are medically inaccurate and misleading, as there is no credible scientific evidence that abortion causes an increased risk of such conditions. Trial Tr. vol. I (AM), 85:1-11, 86:6-21 (Nauser); Pls.' Ex. 68, at 148-49, 152-53 (NASEM, The Safety and Quality of Abortion Care in the U.S.).

197. The mandated disclosures suggesting that fetuses can feel pain at 22 weeks LMP are irrelevant to Plaintiffs' abortion patients, whose pregnancies measure no later than 21 weeks 6 days LMP. See Trial Tr. vol. I (AM), 95:3-20 (Nauser); Trial Tr. vol. I (PM), 93:12-25 (Alsaden).

198. The disclosures about fetal pain are also medically inaccurate, and misleading. Pain, as defined by the IASP—a highly regarded organization of clinicians and scientists who study pain—is "an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage." Trial Tr. vol. VII (AM), 80:9-25, 82:3-14, 83:5-21 (Ralston); Pls.' Ex. 75 (IASP, Revised IASP Definition of Pain); see also Trial Tr. vol. VI (AM), 56:7-13 (Pierucci); *id.* at 107:16-20, 110:4-7 (Condic).

199. Under this accepted IASP definition, consciousness is required to feel pain. Trial Tr. vol. VII (AM), 80:9-25, 82:3-14, 83:5-21 (Ralston). Consciousness cannot occur until the necessary connections of pain fibers to the cortex have developed, which does not occur until at least 24 weeks LMP. Trial Tr. vol. VII (AM), 67:25-68:16, 79:25-80:8, 88:9-92:9, 94:13-95:22, 118:18-24, 120:18-24 (Ralston).

200. The medical consensus, as reflected by the positions of ACOG, SMFM, and RCOG—all of which are the preeminent medical organizations in their subspecialty fields—is that fetuses cannot feel pain before at least 24 weeks LMP. Trial Tr. vol. VII (AM), 67:25-68:16, 69:5-23, 73:24-74:11, 76:1-8, 78:21-79:11, 79:25-80:8 (Ralston); Pls.' Ex. 74 (ACOG, Facts - Gestational Development & Capacity for Pain); Pls.' Ex. 71 (RCOG, Fetal Awareness Review (2022)); Pls.' Ex. 73 (SMFM, Use of Analgesia & Anesthesia for Maternal-Fetal Procedures); see also Trial Tr. vol. VI (AM), 32:4-13, 46:20-25 (Pierucci); *id.* at 101:6-102:14, 102:24-104:11 (Condic). Indeed, the more persuasive evidence is that those connections do not commonly exist before approximately 28 weeks—and perhaps later.

201. Accordingly, the statement that "by no later than 20 weeks from fertilization"—i.e., 22 weeks LMP—"the unborn child has the physical structures necessary to experience pain" is not scientifically accurate, as fetuses lack the necessary cortical connections to experience pain at 22 weeks LMP. Trial Tr. vol. VII (AM), 106:1-18 (Ralston).

202. And the statement that "[t]here is evidence that by 20 weeks from fertilization unborn children seek to evade certain stimuli in a manner that in an infant or an adult would be interpreted to be a response to pain" is scientifically inaccurate and

misleading because fetuses at that gestation do not "seek to evade" noxious stimuli when they reflexively withdraw from such stimuli. Trial Tr. vol. VII (AM), 106:19-107:20 (Ralston). Testimony revealed that fetal facial expressions, limb withdrawals, and stress responses after exposure to noxious stimuli (inputs that cause actual or potential tissue damage) are unconscious, reflexive responses that do not indicate that a fetus is feeling pain before 24 weeks LMP. Trial Tr. vol. VII (AM), 84:12-85:16, 86:21-88:5, 96:18-99:2 (Ralston); Pls.' Ex. 75 (IASP, Revised IASP Definition of Pain); Trial Tr. vol VI (AM), 110:22-24 (Condic).

203. Testimony also revealed that to prevent fetal reflex responses during fetal surgery, MFMs typically administer analgesia, rather than anesthesia. *Id.* at 99:3-101:16 (Ralston). Analgesia is not commonly administered to fetuses before 24 weeks LMP, nor is fetal anesthesia. *Id.* Thus, the statement "[a]nesthesia is routinely administered to unborn children who are 20 weeks from fertilization or older who undergo prenatal surgery" is scientifically inaccurate because fetuses are typically given analgesia or neuromuscular blockades rather than anesthesia, and the statement is also misleading because it implies that the purpose is to blunt the perception of pain. *Id.* at 107:21-108:11 (Ralston). It is not; instead, the purpose is to paralyze fetal tissue to reduce reflexive involuntary movement during the procedure.

204. Contrary to Dr. Pierucci's testimony (and several others for the State Defendants) that all of the statements regarding embryonic and fetal development in the KDHE-published materials are medically accurate, Trial Tr. vol. VI (AM), 20:7-26:10 (Pierucci), a published scholarly study that recruited seven experts in human anatomy to assess the medical accuracy of statements regarding embryological and fetal

development in various state health departments' pamphlets, published pursuant to abortion-specific "informed consent" requirements, found 43% of those statements in KDHE's pamphlet to be medically inaccurate or misleading. Trial Tr. vol. III (PM), 118:10-17, 120:17-121:4 (Daniels); see also Defs.' Ex. 157 (Daniels et al., Informed or Misinformed Consent) (admitted by stipulation). These results were largely consistent with the testimony from plaintiffs' witnesses—including Dr. Nauser and Dr Alsaden and several of plaintiffs' experts, who identified scientific/medical inaccuracies.

205. Plaintiffs disagree with the State's message that APR "may be possible" and strenuously object to being conscripted by the APR Mandate to promote a protocol that is, in their clinical judgment, experimental and potentially dangerous. Trial Tr. vol. I (AM), 112:21-116:8, 117:2-21, 118:21-119:2 (Nauser); Trial Tr. vol. I (PM), 98:9-18, 98:23-99:14 (Alsaden); Pls.' Ex. 84 (Creinin, Mifepristone Antagonization with Progesterone); Pls.' Ex. 82 (ACOG, Facts – Medication Abortion "Reversal" Is Not Supported By Science); see also Trial Tr. vol. II (AM), 83:12-25, 84:7-19, 87:3-88:10 (Schreiber).

206. Plaintiffs also object to being compelled to refer patients to the APR Helpline included in the KDHE-published "information on resources available to reverse the effects of a medication abortion that uses mifepristone." K.S.A. 65-6716(e); Trial Tr. vol. I (AM), 119:3-22 (Nauser). Dr. Nauser testified that because APR is "potentially dangerous and experimental" she would not "refer a patient to something that I don't feel comfortable that it's safe to do." Trial Tr. vol. I (AM), 119:19-22 (Nauser). If required to do so, she would stop providing medication abortions due to her conviction that such information is contrary to her professional obligations to her patients. Trial Tr. vol. I.

(AM), 121:23-122:8 (Nauser). Likewise, CH would also stop providing medication abortions, if the APR Mandate were implemented and required.

207. The APR protocol necessarily entails deviating from the two-drug medication abortion regimen by not following mifepristone with misoprostol—i.e., "mifepristone monotherapy." Trial Tr. vol. II (AM), 81:8-82:9 (Schreiber); Trial Tr. vol. II (PM), 25:1-30:7 (Schreiber). Mifepristone monotherapy can result in three possible outcomes: (1) an abortion, potentially "in a more slow fashion or over time"; (2) the pregnancy stops growing due to the uterine lining loosening and the pregnancy tissue detaching, but the pregnancy tissue remains in the uterus and is not expelled; or (3) the pregnancy continues growing. Trial Tr. vol. II (AM), 62:22-63:8 (Schreiber); see also FOF ¶ 131. Mifepristone monotherapy may lead to safety risks to the patient, like hemorrhage. *Id.* at 63:9-18, 82:21-83:1 (Schreiber); Trial Tr. vol. II (PM), 25:3-11 (Schreiber); Trial Tr. vol. I (AM), 115:4-14, 117:19-21 (Nauser); Trial Tr. vol. I (PM), 99:1-100:3 (Alsaden); Pls.' Ex. 84 (Creinin, Mifepristone Antagonization with Progesterone).

208. Aside from requiring providers to deviate from standard treatment for medication abortion, APR is also unlikely to be biologically plausible. Trial Tr. vol. II (AM), 64:4-8 (Schreiber). Mifepristone has a higher bonding affinity with—and binds more tightly to—a progesterone receptor than does progesterone. *Id.* at 60:21-61:2, 64:11-15, 65:2-5 (Schreiber). Progesterone levels are already high during pregnancy, and so it is unlikely that additional progesterone could displace mifepristone from a receptor site. *Id.* at 64:9-65:5 (Schreiber); Trial Tr. vol. II (PM), 42:8-20 (Schreiber); Trial Tr. vol. I (AM), 117:11-15 (Nauser). Moreover, once mifepristone binds to the progesterone receptor, intracellular effects occur that cannot be undone, even if the

mifepristone were somehow displaced from the receptor. Trial Tr. vol. II (AM), 60:21-61:15, 65:6-19 (Schreiber) (mifepristone unwinds the pregnancy-supporting impacts of progesterone). Thus, there is no reliable and scientifically-valid evidence that "it may be possible to reverse a medication abortion that uses mifepristone." Trial Tr. vol. II (AM), 67:11-68:1, 70:15-79:15, 83:12-24 (Schreiber); Trial Tr. vol. I (AM), 117:16-21 (Nauser); Pls.' Ex. 69, at e33 (ACOG, Medication Abortion Up to 70 Days of Gestation). Simply put, literature purporting to support APR—including the two articles upon which the State relies (discussed below)—is extremely limited in scope, methodologically flawed, and does not demonstrate that APR is either safe or efficacious. Trial Tr. vol. II (AM), 70:1-11, 79:10-15 (Schreiber). The same is true of several analogies used by the State Defendants' experts (DMPA and Narcan, as analogous examples demonstrating plausible efficacy).

209. The first article relied upon by the State Defendants "tells the stories of six women who took mifepristone and then were given progesterone after the mifepristone and before the misoprostol." *Id.* at 71:14-18 (Schreiber). The described patients received progesterone through different means (orally, by injection, as a suppository) and over varying lengths of time. *Id.* at 72:8-20 (Schreiber). It is a case report, which is typically not used to draw causal conclusions or change clinical practice, and no conclusive evidence about APR can be drawn from the paper. *Id.* at 68:20-69:12, 71:19-22, 72:21-73:23 (Schreiber).

210. The second article is "somewhere between a cohort study and a case series" of 547 patients who received progesterone from one of 325 medical professionals. *Id.* at 74:21-75:5, 75:22-25, 77:5-10 (Schreiber); Defs.' Ex. 133 (Delgado

2018). The patients in this paper received progesterone in “a large variety of different delivery systems, routes, and also length of time of use”; these significant differences and variables reduce the ability to draw any conclusions from such a study. Trial Tr. vol. II (AM), 77:11-78:4 (Schreiber). It does not track or follow the traditional scientific method. The case survey/paper also did not control for gestational age, which can affect the rate of success of mifepristone and the rate of continuing pregnancy. *Id.* at 78:19-79:5 (Schreiber). Most importantly, the authors included in the paper only individuals who were already found to have continuing pregnancies ***prior to*** the first dose of progesterone, so “there’s no evidence that anything about this intervention [progesterone] changed anything.” *Id.* at 76:1-77:4 (Schreiber); Trial Tr. vol. II (PM), 9:7-13 (Schreiber). After publication, the paper was retracted for an IRB-related issue, although later republished. Trial Tr. vol. VII (AM), 28:16-30:19 (Curlin).

211. Additionally, the fact that a Depo-Provera (a synthetic progestin—not natural progesterone), also known as Depot Medroxyprogesterone Acetate (“DMPA”), injection at the time of mifepristone administration may slightly increase the risk of an ongoing pregnancy does not reasonably support the biological plausibility of APR, which relies upon administration of progesterone. Trial Tr. vol. I (PM), 48:6-49:16 (Nauser); Trial Tr. vol. II (PM), 38:25-40:3, 44:19-45:9 (Schreiber). Further, any statistically-reported slight increase in the rate of continuing pregnancy after administration of DMPA, which “mimics” but is not progesterone, is still within normal failure rate for mifepristone/medication abortion efficacy. Trial Tr. vol. II (PM), 44:19-45:9 (Schreiber) (the rate of continuing pregnancy in patients who received DMPA at the same time as mifepristone was “extremely low” and “within the normal range of medication abortion

efficacy"); Trial Tr. vol. I (PM), 49:7-16 (Nauser). Thus, DMPA analogies do not substantiate or demonstrate the safety and/or efficacy of APR theory.

212. Similarly, the fact that Narcan/naloxone can be used to reverse an opiate/opioid overdose does not support the biological plausibility or efficacy of APR theory. Trial Tr. vol. I (PM), 49:17-50:4 (Nauser). It is a false analogy. Narcan has a higher bonding affinity for opioid receptors than typical opiates/opioids themselves, and therefore, it can displace an opiate/opioid from the receptor. By contrast, mifepristone has a higher affinity for progesterone receptors than progesterone, and therefore it is unlikely that additional progesterone can or does displace mifepristone—once bound to a receptor. *Id.* at 49:21-50:1 (Nauser); Trial Tr. vol. II (PM), 42:12-20 (Schreiber) (noting that mifepristone "is actually the reversing agent of the progesterone, not that the progesterone is the reversing agent of the mifepristone").

213. APR has simply not been adequately tested for safety in a scientifically validated manner. The articles upon which the State relies do not report on risk of adverse events for the pregnant person. Trial Tr. vol. II (AM), 70:12-14, 79:6-9 (Schreiber); see generally Defs.' Ex. 133 (Delgado 2018). The only randomized controlled trial that attempted to study the safety and efficacy of APR had to be halted early due to safety concerns. Trial Tr. vol. II (AM), 79:16-83:3 (Schreiber); Trial Tr. vol. I (AM), 115:4-14 (Nauser); Trial Tr. vol. I (PM), 99:17-100:3 (Alsaden); Pls.' Ex. 84 (Creinin, Mifepristone Antagonization with Progesterone).

214. No illustrated need for the information conveyed by the APR Mandate was demonstrated. Dr. Nauser—one of the few abortion providers in the State—has never had a patient seek APR or information on it. Trial Tr. vol. I (AM), 120:8-13 (Nauser).

Neither Plaintiff provides APR, and in the "very rare case that patients change their mind about having an abortion after taking mifepristone and want to continue their pregnancy," ACOG recommends expectant management. Trial Tr. vol. I (AM), 113:1-3 (Nauser); Trial Tr. vol. I (PM), 99:9-11 (Alsaden); Trial Tr. vol. II (AM), 67:11-68:1 (Schreiber); Trial Tr. vol. II (PM), 41:22-42:7 (Schreiber); Pls.' Ex. 69, at e33 (ACOG, Medication Abortion Up to 70 Days of Gestation).

215. Given the existing state of medical evidence and the totality of evidence presented at trial, APR theory is just that—theory. It is unproven with significant potential health risks to pregnant women that engage in such a practice. Its contemplated use and the disclosure through the APR Mandate undermine maternal health and safety (given these risks) and would serve to mislead and confuse women contemplating the termination of a pregnancy. Given the record before the Court, it is a concept that is antithetical to informed consent because it makes the decision of whether to terminate a pregnancy or not appear less binary and less final/irreversible, based upon what amounts to junk science.

The mandatory disclosures' detrimental impacts on care.

216. The WRTKA affords providers no discretion to omit any of the state-mandated disclosures, even if the provider believes a disclosure to be irrelevant, inaccurate, and/or potentially distressing or harmful to a particular patient. Trial Tr. vol. I (AM), 88:15-89:2, 91:4-10, 98:7-17, 100:12-101:2 (Nauser).

217. Receiving medically immaterial, inaccurate, and/or misleading disclosures from Plaintiffs caused confusion and distress to Plaintiffs' patients. Trial Tr. vol. I (PM),

18:4-13, 47:8-48:2, 88:15-89:2, 91:4-10 (Nauser) (CWH patients whose pregnancies were affected by a fetal diagnosis were "emotional" and "confused" because they "don't understand" why they have to "have a 15-page packet of consents"); *id.* at 98:7-14 (Nauser) (mandated disclosures about fetal pain "upset patients when they are further pregnant"); Trial Tr. vol. I (PM), 129:19-25, 133:15-21 (Alsaden) ("[T]erms like father, unborn child, uniquely separate human being . . . pose a risk of causing patients to have negative feelings or feel stigmatized in their choice to have an abortion.").

218. The WRTKA's mandated disclosures distract from the information that is, in Plaintiffs' clinical judgment, truly material to patients' consent to an abortion, causes patients to question why their providers are sending mixed messages—including ones that discourage abortion—and wedge the State's often stigmatizing message that childbirth is preferrable to abortion into the informed consent process. Trial Tr. vol. I (AM), 104:18-105:10, 107:3-12 (Nauser) (giving abortion patients a list of adoption services "guilt[s] and shame[s] them"); *id.* at 62:20-63:1 (Nauser) (WRTKA consent packets were 11 and 15 pages); Trial Tr. vol. I (PM), 28:19-22 (Nauser); Defs.' Ex. 39 (CWH-0000593); Defs.' Ex. 41 (CWH-0000570); Trial Tr. vol. I (PM), 88:22-90:5, 94:1-12, 133:13-21 (Alsaden); Trial Tr. vol. IV (AM), 125:7-13, 126:19-25, 131:22-132:4 (Wynia); Trial Tr. vol. VII (AM), 32:7-15 (Curlin).

219. Compelling providers to convey mandated disclosures that are medically inaccurate and/or misleading erodes patients' trust, invades the provider-patient relationship, and "is the antithesis of informed consent." Trial Tr. vol. I (AM), 87:6-16, 107:20-108:8 (Nauser); Trial Tr. vol. I (PM), 97:10-17 (Alsaden) ("using us as vessels" for "medical misinformation" violates the "oath to do no harm"); Trial Tr. vol. IV (AM),

124:2-8, 125:18-19, 126:13-16, 131:14-18 (Wynia) ("[A]t best, it is a roadblock or a stumbling block in establishing a relationship of trust. At worst, it turns into a wall that actually causes the patient to not want to come back and see you again or not trust everything that you're saying."); *cf.* Trial Tr. vol. VI (PM), 45:12-19 (Curlin).

220. Further, the mandated informational overload attendant to these disclosures actually obscures the material information from patients by diluting the messaging that the provider, consistent with the standard of care, determines is appropriate and necessary. Trial Tr. vol. I (AM), 29:10-22 (Nauser) (giving more information than that which "are relevant to [patients] personal clinical situation…confuses the patients more"); *id.* at 108:3-6 (Nauser) (patient forced to decide whether the state or doctor is giving her the correct information); Trial Tr. vol. I. (PM), 97:1-6 (Alsaden) (the volume of information received by patients can make it confusing for them to weigh its credibility); Trial tr. vol. IV (AM), 137:5-18 (Wynia) (mandated disclosures put physicians in a position of having to "hope that now the patient is not distracted" by the medically irrelevant information that "may actually be detrimental to their decision"); Trial tr. vol. V (PM) 14: 15-18 (Wubbenhorst) (physicians must "counsel [patients considering irreversible procedures] very carefully").

221. By compelling Plaintiffs to convey the State's message that it "may be possible to reverse the intended effects of a medication abortion that uses mifepristone," the APR Mandate distorts the informed consent process with statements immaterial to medication abortion's risks, benefits, and alternatives, and it suggests/implies that patients need not be fully certain in their decision to obtain a medication abortion. Trial Tr. vol. I (AM), 121:17-22 (Nauser) ("[T]hat's the antithesis of

informed consent. I'm being instructed by the state to give them information that I don't believe is safe."); Trial Tr. vol. I (PM), 42:7-43:7 (Nauser); *id.* at 100:18-101:7 (Alsaden); Trial Tr. vol. II (AM), 84:7-19, 85:5-87:21 (Schreiber) (APR Mandate is "the opposite of informed consent"); Trial Tr. vol. IV (AM), 135:2-23, 139:4-9 (Wynia) (APR Mandate's disclosures do not comply with the standard of care for obtaining informed consent for experimental treatment); Trial Tr. vol. II (PM), 75:2-4 (Sawicki) ("The whole idea is the informed consent is supposed to help the patient achieve their treatment goals, and this seems different."); see also *id.* at 73:12-75:4 (Sawicki) (even assuming disclosure was accurate, there is no common-law duty to discuss a treatment and then disclose to the patient what steps they could take to make the treatment less effective).

222. The APR Mandate further interferes with the provider-patient relationship by compelling providers to convey a message that is contrary to their medical judgment and that they fear will confuse and even harm patients. Trial Tr. vol. I (PM), 42:7-21 (Nauser) (APR Mandate compels providers to "put into a patient's mind from the get-go if you take this pill you might be able to reverse it, when I know that is not really a true statement and it is dangerous"); *id.* at 99:1-100:3, 100:11-101:7 (Alsaden) ("Because this oversteps my rights as a physician to share information with patients that is medically accurate and with the standard of care, and being forced to tell patients statements that are factually untrue and could harm them . . . I am not willing to do that as a physician and a human being."); Trial Tr. vol. II (AM), 83:19-85:4, 86:12-22, 87:22-88:10 (Schreiber) (statements in the APR Mandate may "confuse" or harm patients because "there really isn't . . . any real data to suggest that this intervention might work, or that stopping a medication abortion in the middle of it is safe"); Trial Tr. vol. IV (AM),

136:23-137:1 (Wynia); cf. Trial Tr. vol. VI (PM), 45:12-13 (Curlin) ("I think it's crucial that physicians not say something they believe is false.").

223. The requirement that Plaintiffs convey the APR Mandate disclosures by telephone or in person at least 24 hours prior to the medication abortion is impractical and would obstruct Plaintiffs' ability to provide abortion care, particularly medication abortions. Trial Tr. vol. I (AM), 120:20-121:3 (Nauser); Trial Tr. vol. III (AM), 24:1-25:3 (Wales).

224. The APR Mandate's requirement for large signs to also be posted in each waiting room and consultation room used by patients seeking medication abortion would affect other patients and individuals, including patients that are not only seeking other healthcare but may not seek treatment at all. Trial Tr. vol. I (AM), 121:4-16 (Nauser); Trial Tr. vol. III (AM), 24:4-9, 25:4-20 (Wales).

225. Significantly, if the APR Mandate were to be enforced, Plaintiffs would stop providing medication abortion altogether. Trial Tr. vol. I (AM), 121:22-122:8 (Nauser); Trial Tr. vol. I (PM), 100:4-17 (Alsaden); Trial Tr. vol. III (AM), 25:21-26:6 (Wales).

226. If Plaintiffs stopped providing medication abortion as a result of the APR Mandate, that would dramatically reduce the availability of abortion appointments in Kansas, which would mean fewer people being able to access abortion in Kansas and delayed care for those who are still able to access it. Trial Tr. vol. III (AM), 26:7-28:4 (Wales). And an overwhelming percentage of abortions within the state of Kansas are through medication abortion. Pretrial Order, Index No. 630, at 10, ¶ 17-18 (Def. Fact 51-52) (76% of abortions provided by Planned Parenthood during FY2020 were medication

abortions; during FY2024, 77% of the abortions provided by Planned Parenthood were medication abortions); Trial tr. vol. III, 26:9-10 (Wales) (over 60% of Planned Parenthood's abortion patients choose medication abortion).

227. Disclaiming the mandated disclosures with which physicians disagree would not mitigate the harms imposed by the repetitive and questionable disclosures. Trial Tr. vol. IV (AM), 137:5-20 (Wynia); Trial Tr. vol. I (PM), 42:7-18 (Nauser); accord *id.* 43:20-44:5 (Nauser); *id.* at 96:9-97:6 (Alsaden); Trial Tr. vol. I (AM), 108:1-8 (Nauser). The disclosures put the patient in the position of "hav[ing] to decide who's giving correct information, the state or the doctor." Trial Tr. vol. I (AM), 108:1-8 (Nauser); accord Trial Tr. vol. I (PM), 42:7-18, 43:20-44:5 (Nauser); *id.* at 96:9-97:6 (Alsaden); Trial Tr. vol. IV (AM), 123:19-124:21, 137:2-20 (Wynia). Such a conflict significantly undermines the very nature of the physician-patient relationship and the provision of truly "informed" consent. Trial Tr. vol. IV (AM), 113: 4-18 (Wynia) ("informed consent requires effective communication between patient and doctor."). And it clearly alters the nature of the providers' normal speech and informed consent discussions with their abortion patients. Trial tr. vol. I (AM), 49:12-50:4 (Nauser) (Dr. Nauser would "never ask[]" a patient the most important factor in their decision to get an abortion); *id.* at 85:22-88:10 (Nauser) (WRTKA disclosures require Dr. Nauser to communicate false information that she would not and does not communicate absent the compulsion); *id.* at 107:22-25 (Nauser) (the disclosures require language that Dr. Nauser "would never use"); *id.* at 119:15-22 (Dr. Nauser would not normally refer patients to the APR hotline); *id.* at 122:5-8) (Nauser) (H.B. 2264 asks physicians to violate the Hippocratic Oath); Trial Tr. vol. II (AM), 30:20-24; 32:12-33:1 (Alsaden) (would not use terms such as "unborn child" or

"father" absent WRTKA requirements); Trial tr. vol. II. (PM), 133:23-134-7 (Wales) (but for WRTKA, Planned Parenthood would not publish "information about providers, states of residence, their training, their insurance" among other things); Trial tr. vol. III (AM), 16:11-17:7 (Wales) (Planned Parenthood would not willingly publish potentially medically inaccurate and/or stigmatizing language); *id.* at 21:5-22:3 (a physician would not normally document, in an electronic health record, the reason a patient sought an abortion and nobody wanted to be the person who had to ask such "insulting questions" of patients); Trial Tr. vol. IV (AM), 125:14-126:18 (Wynia) (it would be inappropriate for a physician to say that an "abortion will terminate the life of a whole, separate, unique, living human being" because physicians are supposed to provide medically relevant information, not the physicians "point of view about [the] morality" of abortion).

228. The WRTKA's requirements to make voluminous, repetitive, state-scripted disclosures—many of which are neither relevant to individual patients nor medically material to the proposed abortion's risks, benefits, or alternatives—in multiple hyper-specific formats, and withhold care for arbitrary periods thereafter, conflicts with the scope of common law informed consent, the principles of medical ethics, the professional standard of care, and Plaintiffs' clinical judgment. Trial Tr. vol. I (AM), 62:20-63:1 (Nauser) (WRTKA consent packets were 11 and 15 pages); *id.* at 92:10-19, 92:3-13, 95:3-20, 104:18-105:10, 106:6-11, 107:3-12 (Nauser); Defs.' Ex. 39 (CWH-0000593); Defs.' Ex. 41 (CWH-0000570); Trial Tr. vol. I (PM), 8:18-23 (Nauser); *id.* at 93:12-25, 97:10-17 (Alsaden); Trial Tr. vol. IV (AM), 124:18-21, 130:15-18, 130:25-131:5, 131:22-24, 132:5-17, 132:18-133:9, 133:23-25 (Wynia); see Trial Tr. vol. II (PM),

53:3-10 (Sawicki) (WRTKA disclosures are not consistent with underlying informed consent principles or how courts have interpreted that duty).

The Reason Mandate's flaws and likely impacts on care.

229. Unlike clinical practice, which "focuse[s] on the individual patient . . . sitting across [from] the health-care provider," public health "exists to prevent disease and illness in communities," so in "public health, our patient is our population, our community." Trial Tr. vol. III (PM), 29:25-30:19 (Lee); accord Pls.' Dep. Desigs. vol. 1, Ex. A, Ahmed (KDHE) Dep. 23:21-24:1 (May 19, 2025) (KDHE's mission is to "protect the health of the public"); *id.*, vol. 2, Ex. C, Lara (KDHE) Dep. 14:19-23 (KDHE's mission is to "improve the health . . . for all Kansas").

230. Because protecting the health of the population sometimes necessitates impingement on the rights of individuals, risks to individuals' privacy or autonomy are ethically permissible only if steps are taken to offset these potential harms and if affected parties—including public health agencies—are included in deliberations and decision-making. Trial Tr. vol. III (PM), 31:3-18, 73:15-20, 74:20-75:1, 87:1-7 (Lee); see *id.* at 34:2-35:17 (Lee) (explaining the considerations in the APHA Code of Ethics guidance for ethical analysis, including reciprocity); Pls.' Ex. 88, at 8 (APHA Code of Ethics) (reciprocity means asking, "Have we done what is reasonable to offset the potential harms and losses that the proposed action imposes on individuals and communities?").

231. These "ethical standards are so important" because "trust really is the currency of public health": "Everything that we do when we work with communities

depends on their trusting us to have their interest in mind and that we are acting on the highest level of ethical scientific and professional standards." Trial Tr. vol. III (PM), 32:20-33:7, 42:11-20 (Lee). Thus, as KDHE acknowledges, if public health authorities make decisions without ethical justification, they risk losing the public's trust, which can decrease the effectiveness of the public health action. *Id.*; Pls.' Dep. Desigs. vol. 1, Ex. A, Ahmed (KDHE) Dep. 24:6-19 (May 19, 2025); see Pls.' Ex. 88, at 5 (APHA Code of Ethics) (identifying "professionalism and trust" as a public health core value because the "effectiveness of public health policies, practices, and actions depends upon public trust gained through decisions based on the highest ethical, scientific, and professional standards").

232. Public health authorities use various data collection tools—including public health surveillance, registries, and research—to inform public health action. Trial Tr. vol. III (PM), 29:4-10, 36:1-9 (Lee); Pls.' Dep. Desigs. vol. 1, Ex. A, Ahmed (KDHE) Dep. 37:10-38:14 (May 19, 2025).

233. Vital statistics is an example of information collected which may inform public health action. See FOF ¶¶ 234-239.

234. To determine the contents of vital reports, "registrars come together with the CDC, the Nation[al] Center for Health Statistics, which is the group responsible for our national vital statistics system," and "the National Association of Public Health Statistics and [I]nformation [S]ystems, or NAPHSIS," which is the "professional organization of vital registrars across the country and people who work at vital registration offices." Trial Tr. vol. III (PM), 56:19-57:18 (Lee). "[F]or the last many decades, together, they decide what data are necessary at the state level so they can

be reported to them and delivered as national statistics." *Id.*; accord Pls.' Dep. Desigs. vol. 1, Ex. A, Ahmed (KDHE) 29:19-30:17 (May 19, 2025).

235. Professional consensus regarding what variables to include and how to use such data is important in vital statistics registration to ensure that there is comparable cross-jurisdiction data; that the data collected is valid, accurate, and reliable; that the minimum necessary data is collected; and that there is an agreed understanding of "what the data are for" and "how they're going to use those data." Trial Tr. vol. III (PM), 57:19-58:10, 82:10-83:3 (Lee).

236. Vital events including birth, stillbirth, death, abortions/induced terminations of pregnancy (considered "ITOP" data), marriage, and divorce are recorded and registered by the states as vital statistics. Trial Tr. vol. III (PM), 55:12-56:18 (Lee); Pls.' Dep. Desigs. vol. 1, Ex. A, Ahmed (KDHE) Dep. 57:7-58:10 (May 19, 2025); *id.,* vol. 2, Ex. D, Smith (KDHE) Dep. 20:11-21:18.

237. Vital statistics registration is generally conducted by requiring reporting of vital events to the relevant public health authority without individual consent. Trial Tr. vol. III (PM), 28:25-29:10, 55:14-20 (Lee); see, e.g., K.S.A. 65-445(a); K.A.R. 28-56-2; accord Pls.' Dep. Desigs. vol. 1, Ex. A, Ahmed (KDHE) 57:7-58:10 (May 19, 2025).

238. In Kansas, KDHE is responsible for ITOP reporting and is authorized to "adopt rules and regulations" to "prescribe, in detail, . . . the information required in the reports that must be submitted." K.S.A. 65-445(a), (b), (i).

239. Prior to the Reason Mandate, consistent with the standard forms recommended by the professional consensus, KDHE required that ITOP reports include

the patient's de-identified biographic data, certain medical history, and certain information regarding the reported abortion. See Trial Tr. vol. III (PM), 57:8-18, 58:11-60:25 (Lee) (pre-H.B. 2749 ITOP reporting variables in K.A.R. 28-56-2 "map quite clearly onto" the variables agreed upon by professional consensus, as reflected in the NAPHSIS technical resource for ITOP reporting); compare Pls.' Ex. 94 fig.1 (NAPHSIS Technical Resource for Reporting of Induced Termination of Pregnancy), with K.A.R. 28-56-2(d), and Pls.' Ex. 6a (Pre-H.B. 2749 ITOP Reporting Form).

240. The questions that the Reason Mandate adds to the traditional ITOP vital statistics reporting requirement depart from the "professional consensus" of registrars like KDHE, CDC, and NAPHSIS regarding the "data that should be collected in the vital registration system." Trial Tr. vol. III (PM), 61:1-61:15 (Lee); contrast Pls.' Ex. 94 fig.1 (NAPHSIS Technical Resource for Reporting of Induced Termination of Pregnancy), with H.B. 2749 § 1(c), (e), and Pls.' Ex. 6b (H.B. 2749 ITOP Reporting Form); see also Pls.' Dep. Desigs. vol. 1, Ex. A, Ahmed (KDHE) Dep. 29:5-31:4 (May 19, 2025) (the Reason Mandate departs from NAPHSIS form); *id.*, vol. 2, Ex. D Smith (KDHE) Dep. 37:24-40:4 (KDHE would not have added additional questions to ITOP but for the Reason Mandate).

241. Additionally, the categories of data added by the Reason Mandate depart from the types of "observable events with observable characteristics" that are reported as part of vital registration. Trial Tr. vol. III (PM), 61:16-62:22 (Lee). For example, although a death certificate might report that a person died of influenza, registrars do not interview the decedent or their family about the reason the decedent contracted influenza. *Id.*; cf. Trial Tr. vol. VI (PM), 85:19-86:5 (Curlin) ("The fact is that we regularly

in public health research count on people to be reporters of their own experience. . . . including their internal experience.").

242. The State does not suggest that the Reason Mandate constitutes vital registration. See Final Pretrial Order, Index No. 630, pg 27 (June 4, 2025) (indicating the Reason Mandate is "public health surveillance"); Trial Tr. vol. V (PM), 57:8-17, 59:8-60:1 (Wubbenhorst) (same); Trial Tr. vol. VI (PM), 85:4-86:19 (Curlin) (suggesting the Reason Mandate is "public health research"). Indeed, unrebutted evidence demonstrates that the Reason Mandate is inconsistent with vital registration.

243. Instead, the State argues the Reason Mandate constitutes public health surveillance, but even its own experts disagree about whether the Reason Mandate constitutes public health surveillance or public health research. Contrast Trial Tr. vol. V (PM), 57:8-17, 59:8-60:1 (Wubbenhorst) (testifying regarding Washington State's stated public health goals for "public health surveillance" of abortion and the goals of "data collection" under the Reason Mandate without specifying what type of data collection system the Reason Mandate entails), with Trial Tr. vol. VI (PM), 85:4-86:19 (Curlin) (opining that the Reason Mandate is ethically justified because it is consistent with "common" and "characteristic feature[s]" of "public health research"). As discussed, supra FOF ¶¶ 78, and 95, the Court credits Dr. Lee's expert testimony regarding the methodological and ethical requirements for public health surveillance and research.

244. Public health surveillance is the "systematic collection, analysis, and interpretation of health data," which is "essential to planning, implementation, and evaluation of public health practice . . . . [, c]losely integrated with the timely dissemination of these data to those who need to know." Trial Tr. vol. III (PM), 37:13-

38:7 (Lee); Pls.' Ex. 90, at 19 (Lee & Thacker, The Cornerstone of Public Health Practice).

245. Public health surveillance collects data without individual consent and, sometimes, without individual knowledge. Trial Tr. vol. III (PM), 29:4-10, 41:12-16 (Lee); Pls.' Dep. Desigs. vol. 1, Ex. A, Ahmed (KDHE) Dep. 23:2-10, 32:4-9, 38:23-39:2 (May 19, 2025).

246. Although the requirement of an *a priori* public health purpose has always been implicit in the definition of public health surveillance, in 2011, the definition was updated to "incorporate[e] explicitly two key principles: 1) the purpose of the activity must be to address a defined public health problem or question and 2) the public health question or questions must exist a priori, that is there must [be a] planned public health purpose to the collection, storage and use of the data." Trial Tr. vol. III (PM), 38:24-40:13, 70:2-13 (Lee); Pls.' Ex. 90, at 19 (Lee & Thacker, The Cornerstone of Public Health Practice); accord Pls.' Dep. Desigs. vol. 1, Ex. A, Ahmed (KDHE) Dep. 23:2-23:20, 32:4-9, 33:5-7, 34:3-37:9, 39:13-24 (May 19, 2025) (public health surveillance requires "a clear reason why we're monitoring what we're monitoring" and the first step in designing a public health surveillance system is "defining the purpose of your surveillance"); *id.* ("[J]ust because we are public health does not mean everything we do is called public health surveillance."). This clarification in 2011 reflects the current consensus definition by the public health community. See Trial Tr. Vol. III (PM), 40:10-13 (Lee).

247. Thus, to be ethically justified, the public health surveillance data collected must be "fed back into" a planned public health action to benefit the community from

whom the data was collected. Trial Tr. vol. III (PM), 42:21-43:8, 63:15-21 (Lee); accord Pls.' Dep. Desigs. vol. 1, Ex. A, Ahmed (KDHE) Dep. Tr. 39:13-24 (May 19, 2025) (unconsented data collection under public health surveillance is ethically justified by benefit to population). "Simply holding the information for the sake of having it is the antithesis of really doing public health surveillance or any public health data collection . . . ." Trial Tr. vol. III (PM), 49:12-15 (Lee).

248. To be usable for public health action and ethically justified, public health surveillance data must be valid and comprehensive. *Id.* at 41:7-21, 54:8-15 (Lee); accord Trial Tr. vol. III (AM), 136:3-138:4 (Kimport).

249. Moreover, a public health authority has an ethical obligation to collect the minimum data necessary to achieve its public health purpose to avoid unjustified risks to individuals' privacy. Trial Tr. vol. III (PM), 42:21-44:11, 52:24-53:2 (Lee).

250. The Reason Mandate does not meet the methodological or ethical requirements of a public health surveillance system. *Id.* at 46:11-47:9 (Lee).

251. First, the text of the Reason Mandate does not identify any *a priori* public health purpose, which is contrary to both the definition of "public health surveillance and the ethical value of professionalism and trust because if the public does "not know why this sensitive data[,] these fields are being collected" and there is no "justification of some counter balance or counterweight or benefit," the public is not going to "trust public health." *Id.* at 47:23-48:13 (Lee).

252. Nor can KDHE identify any public health purpose for the data collection under the Reason Mandate. Pls.' Dep. Desigs. vol. 2, Ex. D, Smith (KDHE) Dep. 27:1-

30:12 (May 19, 2025); Pls.' Ex. 17, at 4-6, 8-9, 16 (KDHE's R&Os to Pls.' 2d Set of ROGs, Rogs. 13-16, 19, 22, 25, 43). Indeed, there was no evidence that the State Defendants presented to support a finding that, at the time of consideration and passage by the Kansas Legislature, there was any legitimate articulated intended purpose for this data collection—much less a public health purpose. The only evidence of an articulated "purpose" by the Legislators at the time indicated that the purpose of the Reason Mandate was to: "[m]ake sure ***we're making the right decision for these women***" who are seeking abortions in Kansas. Pls.' Ex. 11 (House Journal, p. 3420 (Apr. 29, 2024)) (emphasis added). This appears to be an exclusively ideologic and paternalistic purpose—not one related to public health surveillance.

253. KDHE does not plan to take any public health action—much less one for the benefit of the community from which data are gathered (i.e., pregnant women seeking abortion in Kansas)—using the data required by the Reason Mandate. Pls.' Dep. Desigs. vol. 1, Ex. A, Ahmed (KDHE) Dep. 52:5-55:22 (May 19, 2025); *id.*, vol. 2, Ex. D, Smith (KDHE) Dep. 25:12-26:14, 30:22-31:11; accord Trial Tr. vol. III (PM), 47:23-25, 50:24-51:9 (Lee).

254. KDHE's corporate representatives admitted that they are not aware of any public health programs that use ITOP data or any plans to use the additional data sought by the Reason Mandate to inform any public health program or action; in fact, KDHE has no plans to analyze the data sought by the Reason Mandate. Pls.' Dep. Desigs. vol. 1, Ex. A, Ahmed (KDHE) Dep. 52:5-55:22 (May 19, 2025); *id.*, vol. 2, Ex. D, Smith (KDHE) Dep. 25:12-26:14, 30:22-31:11; Pls.' Ex. 17, at 7-11 (KDHE's R&Os to Pls.' 2d Set of ROGs, Rogs. 20, 23, 26, 29).

255. Nor can statements by KDHE about what they will do *in the future* with the data to be ostensibly collected supply an *a priori* public health purpose for the Reason Mandate because any *post hoc* statements would, by definition, not be *a priori*. Trial Tr. vol. III (PM), 49:16-50:5 (Lee).

256. Likewise, supportive legislative testimony by anti-abortion groups or other similar interest groups or like-minded members cannot supply an *a priori* purpose for a statutory enactment because the "public health department would have to decide what they needed the information for. . . . [A]ny interest group could probably find some [data], at least helpful, but that's not a public health purpose necessarily . . . ." *Id.* at 50:6-23 (Lee).

257. Second, unlike a legitimate public health surveillance program, the Reason Mandate is not designed to collect comprehensive or valid data: the option for patients to decline to select the "most important factor" in their decision to seek an abortion prevents the data from being comprehensive and introduces bias that "would be very difficult to quantify [or] correct for," reducing accuracy and leading to potentially erroneous conclusions. Trial Tr. vol. III (PM), 54:5-20 (Lee); Pls.' Dep. Desigs. vol. 1, Ex. A, Ahmed (KDHE) Dep. 40:1-41:4, 63:2-65:3 (May 19, 2025); see also Pls.' Ex. 18, at 6 (KDHE's R&Os to Plaintiffs' 2d Set of RFAs, RFAs 20-22) (explaining potential ways bias may be introduced); Trial Tr. vol. V (PM), 28:15-29:21 (Wubbenhorst) (epidemiologists try to reduce data bias and confounding variables by "try[ing] to account for as many variables as you can").

258. Likewise, the Reason Mandate only collects data from "people who present for abortion care"—excluding people who want, but are unable to obtain, an

abortion and people who choose to carry to term—which makes the data "systematically incomplete." Trial Tr. vol. III (AM), 120:12-121:8, 136:3-138:4 (Kimport); Trial Tr. vol. III (PM), 51:10-52:3 (Lee). "[S]ystematically incomplete" data "makes it impossible to design appropriate actionable responses" as there is a "risk of misunderstanding associations because of an unknown additional variable, and that can lead to any interventions or any actionable responses, not only not resolving any issue but actually making it worse." Trial Tr. vol. III (AM), 136:3-138:4 (Kimport).

259. The Reason Mandate also limits data collection about domestic violence to a subset of people who present for abortion care and made reports of domestic violence within the last 12 months, which "makes it impossible to design appropriate actionable responses" relating to domestic violence. *Id.* at 137:8-138:4 (Kimport).

260. Relatedly, the Reason Mandate contains "vague" questions that "could be interpreted differently" (for example, "financial support" "could mean many different things" like "getting five bucks to catch the bus" or "a month's rent"), as well as compound questions like whether the patient's partner is abusive to the patient or such patient's children, which render it unable to collect valid or useful data. Trial Tr. vol. III (PM), 47:2-6, 53:6-23 (Lee); see also Trial Tr. vol. I (AM), 54:11-55:7 (Nauser).

261. Thus, contrary to Dr. Wubbenhorst and Dr. Curlin's suggestion, Trial Tr. vol. V (PM), 57:8-58:7, 69:18-70:6 (Wubbenhorst); Trial Tr. vol. VI (PM), 84:9-85:3 (Curlin), the Reason Mandate is not capable of producing data about the causal relationship between abortion and social determinants of health or access to contraception because—in addition to data usability issues, supra FOF ¶¶ 257-260—"[c]ausal inference is challenging and multidimensional" and requires "both an

understanding of essential causal factors as well as other complicated factors." Trial Tr. vol. III (PM), 52:8-20 (Lee).

262. Nor is the Reason Mandate capable of improving an individual patient's clinical care as related to social determinants of health or helping individual patients leave abusive situations, cf. Trial Tr. vol. V (PM), 55:6-14, 59:8-61:4, 69:18-70:6 (Wubbenhorst); Trial Tr. vol. VI (PM), 84:9-85:3 (Curlin), because "[p]ublic health surveillance is not designed for individual care." Trial Tr. vol. III (PM), 52:4-7 (Lee).

263. Likewise, contrary to Dr. Curlin and Dr. Wubbenhorst's assertions, Trial Tr. vol. V (PM), 61:5-14 (Wubbenhorst); Trial Tr. vol. VI (PM), 85:4-18 (Curlin), the Reason Mandate is not capable of informing public health action to "preserve the health of future unborn children" because "[t]hese aren't data about or from future children or future fetuses" nor from people who carry to term. Trial Tr. vol. III (PM), 51:10-52:3 (Lee).

264. Both Plaintiffs' and the State Defendants' experts agree that the questions in the Reason Mandate most-closely resemble those topics sometimes addressed in public health research, including because they seek information from pregnant women seeking abortion to purportedly benefit others (like "future unborn children" or pregnant women) and seek to essentially interview patients about their "internal experiences." See Trial Tr. vol. III (PM), 50:24-52:2, 61:16-62:22, 64:24-65:6 (Lee); Trial Tr. vol. VI (PM), 85:4-86:19 (Curlin) (the Reason Mandate is ethically justified because "[f]uture unborn children are often considered in public health research. We think about how what is being done now might go down to the benefits or to the harms of future generations," and "subjective" questions in the Reason Mandate are permissible

because “we regularly in public health research count on people to be reporters of their own experience,” “including their internal experience” (emphasis added)).

265. Research uses information from one group to create generalizable knowledge and, thus, involves participants taking on burdens and risks to generate benefits to others. Trial Tr. vol. III (PM), 62:23-64:2 (Lee).

266. As a result, the ethical requirements for research involving human subjects mandate protections for participants, including IRB approval and procedures for obtaining informed consent prospectively. *Id.* at 64:3-23, 65:7-18, 90:10-21 (Lee); Trial Tr. vol. III (AM), 122:5-123:11 (Kimport); Pls.’ Dep. Desigs. vol. 1, Ex. A, Ahmed (KDHE) Dep. 19:9-21:8 (May 19, 2025).

267. However, the Reason Mandate does not contain the same safeguards as bona fide research because it was not reviewed or approved by KDHE’s IRB,[10] and instead of ensuring informed consent from participants prior to administering survey questions, the Reason Mandate requires providers to question every patient seeking abortion (regardless of whether patients decline to provide their reason for the abortion), without permitting patients to opt out of being questioned altogether or permitting providers to exercise any discretion as to the questions posed. Trial Tr. vol. III (PM), 64:24-66:23, 90:10-21 (Lee); Pls.’ Dep. Desigs. vol. 1, Ex. A, Ahmed (KDHE) Dep. 65:4-18 (May 19, 2025); see Trial Tr. vol. VI (PM), 86:6-19 (Curlin) (the ability to decline to respond to questions is “a characteristic feature of research that people are not coerced

[10] Indeed, as previously noted, there is no evidence that KDHE was ever contacted or consulted with respect to the Reason Mandate, prior to its promulgation and enactment.

into cooperating, but we work with the information we can gain from those who are willing to give it" (emphasis added)); Trial Tr. vol. V (PM), 58:23-59:7 (Wubbenhorst) (suggesting questioning might "not affect" patients because "she's not compelled to answer those questions"); cf. Trial Tr. vol. III (AM), 122:15-123:11 (Kimport) (describing how Dr. Kimport's research about pregnancy decision-making has safeguards like IRB review).

268. The Reason Mandate also threatens patient privacy by requiring them to hand over sensitive, potentially personally identifying information without any protection from disclosure. For example, K.S.A. 65-445 prohibits disclosure of information that could identify a provider, but it does not contain any prohibition on disclosure of information that could be used to identify a patient. K.S.A. 65-445(f)-(h).

269. The collection of a patient's sensitive, personal experiences as information, coupled with the biographic information, puts patients at risk for re-identification, which may cause physical, financial, emotional, or social risk to these patients. Trial Tr. vol. III (PM), 52:21-53:5, 88:9-89:17 (Lee); see Pls.' Dep. Desigs. vol. 2, Ex. D, Smith (KDHE) Dep. 41:19-42:5 (May 19, 2025) (information in ITOP reports could be used to identify patients). KDHE acknowledges this risk, especially to patients from cities/towns with small populations or those who are minorities. Trial Tr. vol. III (PM), 89:3-17 (Lee); Trial Tr. vol. III (AM), 106:19-107:6 (Wales); Pls.' Dep. Desigs. vol. 2, Ex. D, Smith (KDHE) Dep. 37:24-40:4, 41:19-42:5 (May 19, 2025). The Reason Mandate fails to minimize this risk. See FOF ¶ 268.

270. The reasons people seek abortion and the socioeconomic challenges pregnant women face can be—and have been—studied through research, including

survey studies. Trial Tr. vol. III (AM), 131:3-25 (Kimport); Trial Tr. vol. III (PM), 66:24-67:18 (Lee). To the extent the State Defendants, the Legislature, or the State of Kansas wanted to further study, in an ethically and methodologically sound manner, the reasons why pregnant women seek abortion, it could conduct its own voluntary research study using valid questions or it could disaggregate Kansas-specific data from the national-level data in existing research. Trial Tr. vol. III (PM), 66:24-67:18 (Lee).

271. In sum, there is no credible and relevant evidence demonstrating any existing significant health-related problem that the Reason Mandate was intended to address and/or potentially solve or that the Legislature was specifically contemplating such a concern in its efforts.

272. If enforced, the Reason Mandate would compel Plaintiffs to ask their abortion patients invasive questions to solicit information that is not clinically relevant, that they would not otherwise ask, and to which they vehemently object. See, e.g., Trial Tr. vol. I (AM), 49:12-50:4, 52:8-12, 52:20-25, 53:9-16, 54:11-23, 55:8-10, 55:17-23, 56:6-13, 57:25-58:11 (Nauser) (questioning required by the Reason Mandate is "not anything I need to know to take care of [patients] safely"); Trial Tr. vol. I (PM), 102:18-20 (Alsaden) ("no clinical value" in asking questions required by the Reason Mandate); accord Trial Tr. vol. IV (AM), 139:23-140:4 (Wynia) ("[The Reason Mandate] requires physicians to ask, or someone in the office to ask, a series of questions of patients, some of which are fairly intrusive, potentially stigmatizing, and for reasons that are unclear, unspecified, and . . . these questions would not normally be asked."); cf. Trial Tr. vol. V (PM), 53:9-20 (Wubbenhorst) (doctors may ask patients about the reason they

are seeking an "elective procedure" to determine if it is "appropriate medically for them or not appropriate given the specific condition" (emphasis added)).

273. The rigid list of reasons also does not reflect patients' often complex and multifactorial decisions to seek abortion, as demonstrated by the testimony of the State's own patient witness Melissa Cole that "[t]here is actually not one [listed reason] that really describes what [she] went through" for one of her abortions. Trial Tr. vol. III (AM), 131:3-8 (Kimport); Trial Tr. vol. IV (PM), 87:18-88:7 (Syrett); Trial Tr. vol. I (PM), 101:16-23 (Alsaden); Trial Tr. vol. V (AM), 47:25-48:14, 51:1-11 (Cole).

274. Some patients are likely to be upset by the insensitive and judgmental phrasing of several of the Reason Mandate's listed reasons—for example, the suggestion that patients have "too many" children may imply that a patient regrets giving birth to their existing children and is "insulting" to the patient. Trial Tr. vol. I (AM), 52:8-19 (Nauser); Trial Tr. vol. III (AM), 22:4-20 (Wales).

275. Patients may also feel stigmatized because the Reason Mandate asks "abortion patients and only abortion patients to explain why they are choosing this pregnancy outcome, and in so doing, . . . it marks choosing abortion as something that needs to be explained," and thus, as "something that's abnormal" or "deviant." Trial Tr. vol. III (AM), 130:6-23 (Kimport); Trial Tr. vol. IV (PM), 87:18-88:7 (Syrett).

276. This stigmatization occurs even though patients may decline to respond to the question about their reason for the abortion. *Id.* at 132:1-6 (Kimport).

277. The sensitive and potentially-distressing topics the Reason Mandate would force providers to probe include whether someone is in an abusive relationship,

has been raped, or is a victim of incest—using blunt, state-scripted language, which may significantly upset or re-traumatize the patient; this may in turn, "negatively impact[] the patient's interest in engaging in further healthcare, even healthcare unrelated to the initial reason why they were speaking with that provider." *Id.* at 134:8-22 (Kimport); Trial Tr. vol. I (PM), 103:13-105:23 (Alsaden); Trial Tr. vol. IV (AM), 140:9-15 (Wynia); Trial Tr. vol. III (PM), 43:18-44:9, 88:9-24 (Lee); cf. Trial Tr. vol. III (AM), 135:19-136:2 (Kimport) (best practices for screening for domestic violence "affords the provider discretion . . . . to choose when, if, and how to engage with patient regarding domestic violence"); Trial Tr. vol. IV (AM), 141:6-21 (Wynia) ("There's a whole set of ways that we talk to people about trauma that they may have undergone that is designed to create an environment of trust and openness and where you let them tell you what happened at their own pace and in their own words, and you are very clear about why you're asking about this thing that may have happened to them."); Pls.' Ex. 205, at 3-4 (ACOG Committee Opinion 554) (recommendations for creating a "safe and supportive environment for assessing and responding to reproductive and sexual coercion," and noting "language is important").

278. Being compelled to report whether each abortion patient reported having experienced domestic violence in the 12 months prior to their visit will not help Plaintiffs (or anyone else) identify coercion with respect to their present desire to terminate a pregnancy. Trial Tr. vol. I (AM), 56:14-57:13 (Nauser); Pls.' Ex. 205, at 3-4 (ACOG Committee Opinion 554) (noting potential concerns for patient safety and confidentiality that result from mandatory reporting regarding domestic violence).

279. Additionally, providers may not have the resources to help patients if, for example, patients respond that they are not living in a place that they consider to be safe, stable, and affordable. See Trial Tr. vol. I (AM), 58:12-23 (Nauser) ("I'm not a social worker, so I don't know what I would even do with that information.").

280. The information sought by the Reason Mandate would erode trust in the physician-patient relationship and intrude on patient privacy and on self-determination with respect to their health care. Trial Tr. vol. III (PM), 43:18-44:9, 88:9-24 (Lee); Trial Tr. vol. III (AM), 21:16-22:3 (Wales); *id.* at 134:8-22 (Kimport); Trial Tr. vol. IV (AM), 139:23-140:4, 142:3-6 (Wynia). As Dr. Nauser explained, "It's actually destroying trust from the very beginning because I'm being made to potentially ask questions that have no medical relevance or clinical relevance, and it's going to make [patients] wonder why they're being asked such invasive questions in the first place. How do they answer them[?] Are they going to be judged by their answer[?] . . . I don't think most of the patients will give an honest answer and feel comfortable with their interaction with me from the very beginning." Trial Tr. vol. I (AM), 51:7-52:1 (Nauser). Dr. Alsaden agreed that "adding arbitrary things in . . . the [R]eason [M]andate which are not medically indicated . . . would undermine" the physician-patient relationship. Trial Tr. vol. I (PM), 105:12-23 (Alsaden).

281. Although "declines to answer" appears as an option for only one of the Reason Mandate's several mandated inquiries, H.B. 2749 § 1(c), patients may feel pressured to answer and fearful—both of how their answers may be used and the consequences of declining to answer. Trial Tr. vol. III (PM), 90:22-91:3 (Lee); Trial Tr. vol. I (PM), 104:23-105:8 (Alsaden).

282. Nor does the "decline to answer" option undo the damage of the Reason Mandate upon patients' trust in their provider. Trial Tr. vol. I (AM), 53:9-16 (Nauser).

283. As a result, the Reason Mandate violates the medical ethical principles of autonomy, beneficence and nonmaleficence, and justice, and it prevents physicians from providing patient-centered care. Trial Tr. vol. IV (AM), 142:7-143:4 (Wynia); see also Trial Tr. vol. I (AM), 51:7-52:1 (Nauser). Thus, it would not, in fact, further any interest relating to the integrity of the medical profession or to protecting vulnerable patients. Trial Tr. vol. IV (AM), 143:5-9 (Wynia).

284. Contrary to Dr. Wubbenhorst's incongruous and unexplained suggestion that the Reason Mandate will prevent abortion regret, cf. Trial Tr. vol. V (PM), 61:5-14 (Wubbenhorst), the Reason Mandate will increase abortion stigmatization and an associated increase in negative mental and emotional health outcomes for abortion patients. Trial Tr. vol. III (AM), 138:15-23 (Kimport); Trial Tr. vol. VII (PM), 21:21-22:9 (Kimport); see supra FOF ¶¶ 122-24, 217, 222-26, 268-69, 274-76, 280.

Additional facts relevant to plaintiffs' claims and this case.

285. The 24-hour and 30-minute waiting periods, as well as the disclosure of information multiple times, in multiple formats, reflect a stereotype that "women are not capable of making up their mind" or that the State does not "trust women to make up their minds themselves." Trial Tr. vol. IV (PM), 55:4-11, 83:25-84:12, 87:2-11 (Syrett); see Trial Tr. vol. I (AM), 77:13-78:2 (Nauser) ("[T]he patient has to wait 30 minutes to continue to think about their decision because apparently, [according to] the State,

they're not smart enough or haven't thought enough to make that decision before they even came to the office.").

286. Although the WRTKA requires that pregnant women seeking abortion be informed about "financial help for pregnancy, childbirth and newborn care," including the father's liability for child support; "the contact information for counseling assistance for medically challenging pregnancies" and "perinatal hospice services," K.S.A. 65-6709(a)(6), (k), no Kansas law requires that pregnant women seeking any other health care, including prenatal care, receive that information. See Pls.' Ex. 15, at 8 (BOHA RFA R&Os, RFAs 16-18).

287. Notably, the State does not mandate that women who decide to carry their pregnancy to term ever be given these disclosures about these benefits purportedly available to them. See, *e.g.*, Trial Tr. vol. I (AM), 91:23-92:2, 92:14-17 (Nauser).

288. Neither the Subject Laws' content nor the audience to whom it is (and is not) directed is neutral. Instead, through the disclosures, the State puts its "thumb" on the scale in favor of the decision it prefers (procreation, childbirth, and motherhood for woman) while discouraging abortion as the "wrong" choice for a pregnant woman. Trial Tr. vol. IV (PM), 56:8-17 (Syrett) (State may exert reproductive control by "offering certain benefits and rights and advantages to people who behave in one way instead of another"); *id.* at 84:20-85:9, 85:20-86:7 (Syrett) (discussing K.S.A. 65-6709(b)).

289. The WRTKA also requires pregnant women seeking abortion to be "encouraged to seek information on alternatives to abortion, including adoption, and resources available to postpartum mothers," K.S.A. 65-6710, but there is no comparable

requirement that pregnant women seeking prenatal care be encouraged to seek information on alternatives (like abortion) or postpartum resources. See, *e.g.*, Trial Tr. vol. I (AM), 105:3-10 (Nauser). That discrepancy again conveys the State's view that, when a woman becomes pregnant, childbirth is the default (for which no alternative need be considered), and a person considering abortion must consider alternatives.

290. Through the WRTKA's mandated disclosure that "all kinds of things could happen as a result of abortion," but "very little about the also sometimes dangerous undertaking of being pregnant and delivering a child," the State is expressing a clear and obvious preference about what it thinks women should do. See Trial Tr. vol. IV (PM), 86:8-87:1 (Syrett) (discussing K.S.A. 65-6709(a)(1)(A)(3), (7)). In doing so, it conscripts the providers, including plaintiffs, to serve as the State's megaphone for its preferred message—regardless of the provider's personal or professional agreement with or opinion on the compelled content-based discussion/disclosure.

291. The WRTKA's mandated disclosures, waiting periods, and certification requirements interfere with patients' medical decision-making by stripping their autonomy to determine for themselves when they have sufficiently considered their decision to terminate their pregnancy. Trial Tr. vol. I (PM), 23:1-13 (Nauser); Trial Tr. vol. IV (AM), 13:19-14:7 (Ranney) (patients "don't want to have to take the extra steps because they've already made up their mind"); *id.* at 18:17-24 (Ranney) (patients did "not understand[]" why they had to wait 30 minutes during their appointment "when they've already made a decision"); *id.* at 129:23-130:6 (Wynia); The State Defendants' own experts admitted as much. Accord Trial Tr. vol. VII (AM), 32:13-18 (Curlin)

(conceding that not every patient needs a 24-hour waiting period to give valid informed consent to an abortion); *id.* at 35:9-36:18 (Curlin).

292. The Subject Laws' differential treatment of people who seek abortion reflects and reinforces antiquated stereotypes about women's capacity as decision-makers and their role in society, as well as the history of the State exerting control over reproductive decisions to enforce social norms. See Trial Tr. vol. IV (PM), 55:2-15 (Syrett); see also *id.* at 82:22-83:10 (Syrett) (identifying key features of reproductive control measures). Through the Subject Laws, "the [S]tate makes it known how it would like people to behave in terms of reproduction and sexuality," in both explicit and implicit ways. *Id.* at 55:7-9 (Syrett).

293. There was no competent credible and relevant evidence presented at trial that there was (or is) an existing problem relating to a lack of informed consent, as dictated by state common law or applicable professional standards, with respect to pregnant patients. This is true whether for plaintiffs or for the obstetrical community generally in Kansas.

294. There was no competent credible and relevant evidence presented at trial that there was (or is) an existing problem relating to a lack of informed consent, as dictated by state common law or applicable professional standards, with respect to ***any*** population of patients in Kansas or to any group or subset of medical professional.

295. There was no competent credible and relevant evidence presented at trial that pregnant women's health or safety, during the timeframe material to this case, was of concern or reflective of a real and urgent problem that the Kansas Legislature sought

to address through the Subject Laws. In fact, there was no evidence that the existing informed consent process regarding either abortion specifically or obstetrical care more broadly was creating a real and urgent problem that was adversely impacting pregnant women in Kansas and/or their health.

296. The risks to pregnant women substantially increase throughout the course of pregnancy, and the overall morbidity and mortality risk of carrying a child to term greatly exceeds the risks typically associated with abortion, whether medication abortion or procedural abortion. Indeed, childbirth generally carries approximately 13-14 times the risk of procedural abortion. Trial Tr. vol. I (AM), pg. 40:9 through 40:19 (Nauser); see also Exhibit 68, pg. 55, 74-75.

IV. Analysis and Conclusions of Law

A. Plaintiffs have legal standing to pursue their claims, both on their own and on behalf of their current and future patients.

Throughout the pendency of this litigation, the State Defendants have consistently asserted that the plaintiffs, health-care providers that provide abortion care (amongst other services and care) to patients in Kansas, lack standing to pursue the claims in their operative Petition.[11] In a nutshell, the State Defendants argue that the plaintiffs simply cannot pursue claims on behalf of their current and future patients, given what they perceive to be "inherent conflicts" between them and their patients. See Final Pretrial Order, Index No. 630, pg. 48 (citing *Elk Grove United Sch. Dst. v. Newdow*, 542 U.S. 1, 15, 124 S.Ct. 2301, 2311, 159 L.Ed. 2d 98 (2004), abrogated by *Lexmark Int'l, Inc. v. Static Control Components, Inc.*, 572 U.S. 118, 134 S.Ct. 1377, 188

[11] And as further refined and modified through the Final Pretrial Order.

L.Ed. 2d 392 (2014); *June Med. Svcs., LLC v Russo*, 591 U.S. 299, 378, 140 S.Ct. 2103, 2153, 207 L.Ed. 2d 566 (2020), abrogated by *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 142 S. Ct. 2228, 213 L. Ed. 2d 545 (2022) (Alito, J., dissenting)).

However, the Court concludes that the State Defendants' arguments lack merit, given prevailing Kansas law. Even if the Court were to consider the State Defendants' arguments that appear to advocate for application/consideration of ***federal prudential*** standards, which are not constitutional requirements but, rather, are more flexible and discretionary policy-driven considerations, it would, nonetheless, conclude that the Provider plaintiffs may seek to also vindicate the fundamental and natural rights of their current and future patients. Provider plaintiffs have demonstrated that they have a close relationship with their patients, and there are significant legal and practical hindrances to individual patients bringing their own actions to vindicate such rights. Accordingly, the Court concludes that these Plaintiffs have valid legal standing to pursue the claims brought in this case.

1. Kansas law on legal standing.

The Kansas Constitution implicitly limits a court's exercise of judicial power to actual "justiciable" cases or controversies.[12] See *State v. Stubbs*, 320 Kan. 568, 574, 570 P.3d 1209, 1217 (2025) (citing *Gannon v. State*, 298 Kan. 1107, 1119, 319 P.3d 1196 (2014)). And under this "justiciability" requirement, parties must show (among

[12] However, as opposed to the United States Constitution, our state Constitution in Kansas contains no express "case or controversy" requirement. The Kansas Constitution grants "judicial power" exclusively to the courts. Kan. Const. art. 3, § 1. And Kansas courts have repeatedly recognized that "judicial power" is the "'power to hear, consider and determine controversies between rival litigants.'" *See Kansas Bldg. Indus. Workers Comp. Fund v. State*, 302 Kan. 656, 679-80, 359 P.3d 33, 49 (2015).

other things) that they have standing, i.e., the "'right to make a legal claim'" before the court. *Gannon*, 298 Kan. at 1121, 319 P.3d 1196.

"Standing is 'a party's right to make a legal claim or seek judicial enforcement of a duty or right.' Black's Law Dictionary 1536 (9th ed.2009)." *Kansas Bldg. Indus. Workers Comp. Fund v. State*, 302 Kan. 656, 678, 359 P.3d 33, 49 (2015) (citing *Board of Miami County Comm'rs v. Kanza Rail–Trails Conservancy, Inc.*, 292 Kan. 285, 324, 255 P.3d 1186 (2011). "While standing is a requirement for case-or-controversy, i.e., justiciability, it is also a component of subject matter jurisdiction that may be raised at any time." *Gannon v State*, 298 Kan. 1107, 1122, 319 P.3d 1196 (2014). "A justiciable controversy has definite and concrete issues between the parties and 'adverse legal interests that are immediate, real, and amenable to conclusive relief." *State v. Montgomery*, 295 Kan. 837, 840, 286 P.3d 866 (2012) (citing *State ex rel. Morrison v. Sebelius*, 285 Kan. 875, 890–91, 179 P.3d 366 (2008)); see also *Kansas Bldg. Indus. Workers Comp. Fund v. State*, 302 Kan. 656, 678, 359 P.3d 33, 49 (2015).

To establish standing in Kansas courts, parties must satisfy a two-part test: they must demonstrate both a cognizable injury and a causal connection between the injury and the challenged conduct. *State v. Stubbs*, 570 P.3d 1209, 1217 (2025); *League of Women Voters of Kansas v. Schwab*, 317 Kan. 805, 813, 539 P.3d 1022 (2023).[13] The "causal connection" need only be "fairly traceable to the challenged conduct of the defendant," which is generally not viewed as a high bar. *Kansas Bldg. Indus. Workers*

[13] The nature of the burden depends on the stage of the proceedings. See *Gannon*, supra at 1123. In a civil case, such as this one, that standard and burden plaintiffs must demonstrate is a "preponderance of the evidence." *Id.* at 1124. The parties to this matter agree on this standard, as it relates to legal standing. See Final Pretrial Order, Index No. 630, pg. 48 ("They [plaintiffs] therefore must prove the facts establishing the Court's jurisdiction at trial by a preponderance of evidence.").

Comp. Fund, supra at 681-82 (noting federal cases illustrating the low bar). A cognizable injury exists when a party has suffered or faces an actual or threatened injury from the challenged conduct. *League of Women Voters*, supra at 813. The nuances of this analysis will largely hinge upon the specific facts and circumstances of each case. *Stubbs*, 320 Kan. at 576.

2. Differences in federal standing law and "prudential" limits.

As our state's highest court has recently noted, federal courts, which are limited-jurisdiction forums, often also apply supplemental and non-jurisdictional "prudential" considerations and limits on their exercise of jurisdiction. See *Stubbs*, supra at 576. Such prudential standards "embody[] self-imposed judicial restraints on the exercise of jurisdiction." *Kansas Bldg. Indus. Workers Comp. Fund*, supra at 679.

One such "prudential" standing limitation in federal precedent is the general principle that a plaintiff cannot normally advocate for and assert the rights of third parties. *Stubbs*, supra at 1219 (noting the general *federal* prudential rule against "third-party" standing).

However, even under prevailing federal prudential standing authority, there is an exception to this self-imposed limitation. A plaintiff, such as a health-care provider, can assert the rights of others not before the court, if they can "make two additional showings." *Aid for Women v. Foulston*, 441 F.3d 1101, 1111-1114 (10th Cir. 2006) (citing *Kowalski v. Tesmer*, 543 U.S. 125, 130, 125 S.Ct. 564, 160 L.Ed.2d 519 (2004)); see also *June Med. Servs., LLC v Russo*, 591 U.S. 299, 318, 140 S.Ct. 2103, 2118 (2020)("[w]e have long permitted abortion providers to invoke the rights of their actual or potential patient in challenges to abortion-related regulations."); *Singleton v. Wulff*, 428

U.S. 106, 118, 96 S.Ct 2868, 2876 (1976) (plurality opinion) (holding, in light of the prudential third-party standing analysis, "that it is generally "appropriate to allow a physician to assert the rights of women patients as against governmental interference with the abortion decision.").

First, a plaintiff must show that "the party asserting the right has a 'close' relationship with the person who possesses the right." *Kowalski v. Tesmer*, 543 U.S. 125, 130, 125 S.Ct. 564 (2004).

Second, a plaintiff must show a "hindrance" to the possessor's ability to protect his own interests. *Id.*; see also *Aid for Women v. Foulston*, supra at 1111-1112 (citing *Terrell v. INS*, 157 F.3d 806, 809 (10th Cir.1998) ("[t]hird-party standing requires not only an injury in fact and a close relation to the third party, but also a hindrance or inability of the third party to pursue his or her own claims.")).[14]

3. The Provider plaintiffs have demonstrated that they have legal standing to pursue their claims under Kansas law.

Setting aside, for the moment, the issue of "prudential" considerations developed through federal law, the Provider plaintiffs easily satisfy the requirements for legal standing under Kansas law, as they have sufficiently demonstrated that they have and/or will suffer a concrete cognizable injury that is causally connected to the statutory

[14] These self-imposed prudential limits are most commonly analyzed by federal courts in a deferential and relaxed manner and are considered "quite forgiving with these criteria in certain circumstances.... [For example,] '[i]n several cases, this Court has allowed standing to litigate the rights of third parties when enforcement of the challenged restriction against the litigant would result indirectly in the violation of third parties' rights.' " *Kowalski*, 543 U.S. at 130, 125 S.Ct. 564 (quoting *Warth v Seldin*, 422 U.S. 490, 510, 95 S.Ct. 2197 (1997) (emphasis added)); *Aid for Women v. Foulston*, supra at 1112 (permitting health-care providers to assert the constitutional privacy rights of minors that were their patients, given the "closeness" of their relationship and the perceived impediments to those patients' practical ability to vindicate their interest); see also *Singleton*, supra at 118 (1976) (same and permitting abortion providers to assert the rights of their abortion patients). Such authority and perspective is appropriate and persuasive here.

schemes at issue. In fact, the Court finds these injuries highly probable (if not reasonably certain), given the record adduced at trial.

First, the plaintiffs have demonstrated with substantial evidence that they are opposed to, disagree with, and otherwise desire not to comply with various substantive provisions of the Subject Laws: namely, the WRTKA (as amended), H.B. 2264 (2023) (APR Mandate), and/or H.B. 2749 (2024)("Reason Mandate"). Whether the disclosure provisions relating to the WRTKA, the APR Mandate, or the Reason Mandate, plaintiffs unequivocally indicated that they would not provide to or procure from their patients much of the information dictated by those schemes, absent the legislative requirements. They also testified that they considered many of the provisions' obligatory discussions to be scientifically/medically unsupported or incredible, unethical, misleading, and/or dangerous to their patients. Provider plaintiffs further testified that they, as health-care providers, were at risk of professional discipline not only for non-compliance with the Subject Laws but also for compliance, in many circumstances.[15] The evidence reflected that they were further concerned about potential criminal and/or civil liability imposed by the various schemes, if these statutory mandates were implemented and enforced, as currently written.[16] Further, the logical conclusion is that the concrete injuries identified

[15] The Providers articulated that the compelled speech inherent in the WRTKA's required disclosures, including those supplemented through the State's APR Mandate, and the analogous obligations under the Reason Mandate effectively change/alter their speech drastically from what their professional judgment would normally lead them to do. They consider the requirements ethically and medically objectionable and professionally inappropriate. And as a result, these requirements would likely violate their professional and ethical obligations, and/or prove harmful to their patients. Thus, they submit that compliance with the Subject Laws also potentially exposes them to disciplinary action by the Board of Healing Arts.

[16] Beyond these injuries in fact, the Court further notes ample testimony by the Provider plaintiffs that the Subject Laws adversely impacted them and their staffs (and would continue to do so) due to the logistical, administrative, financial, and emotional tolls imposed by those schemes. This, too, is classic "injury in fact" for legal standing purposes.

by the plaintiffs (potential professional discipline, ethical violations, and civil/criminal exposure) naturally follow from the State's enforcement of the schemes at issue, combined with their preferred course of conduct (non-compliance). Thus, their injuries are fairly traceable to the enactments the State Defendants seek to justify. The Provider plaintiffs have proven a quintessential example of actual or threatened injury, as it relates to legal standing. In that regard, the evidence adduced at trial readily demonstrates, in a highly-probable way, the type of "cognizable" injury for which Kansas law confers legal standing to challenge such Legislative enactments.

And, well-established Kansas case law reflects that our state appellate courts have consistently permitted a plaintiff, such as a physician, to represent the interests of others where their rights are necessarily interconnected and at stake in the litigation commenced. See *Alpha Medical Clinic v Anderson*, 280 Kan. 903, 921, 128 P.3d 364, 377 (2006)(citing *Singleton,* supra at 117 and "confirm[ing] petitioners' [providers'] standing to champion" the rights of their individual patients); *Comprehensive Health of Planned Parenthood of Kansas & Mid-Missouri, Inc. v. Kline*, 287 Kan. 372, 406, 197 P.3d 370, 394 (2008)(holding that plaintiff had standing to attempt to neutralize the harms to its patients' constitutional privacy rights that Kline's behavior threatens."); see also *Hodes III,* supra at 967 (affirming Provider plaintiffs' constitutional challenge to abortion statutes and concluding that statutes at issue violated the fundamental right to bodily autonomy ***of the plaintiffs' patients***); *Hodes I,* supra at 614, (holding that Provider plaintiffs were substantially likely to ultimately prevail on their claim that Senate Bill 95 violated ***their patients' rights*** to bodily autonomy); *Trust Women Foundation, Inc. v Bennett*, 509 P.3d 599, No. 121,693 at 10-11, 13 (Kan. App., May 20,

2022)(unpublished)(holding providers had standing to assert claims on their own behalf but also on behalf of their patients).[17]

In this case, the Provider plaintiffs and their patients that seek to obtain abortion care have interconnected and related legal interests with respect to this litigation. The Provider plaintiffs seek relief from State mandates that they believe harm them and infringe upon not only their constitutional rights to free speech during the course of their interactions with their patients but also upon the natural and fundamental rights of their individual patients seeking such professional care. To the extent that the State's legislative mandates at issue impact the providers' rights, in terms of inserting the State into the confidential relationship and mandating delays and compelled speech by way of disclosure/discussion requirements, they directly implicate the patients' own independent rights, as previously established by Section 1 of the Kansas Constitution's Bill of Rights and by the Kansas Supreme Court in *Hodes I*. In that respect, affording legal standing to the Provider plaintiffs to assert the rights of their patients remains entirely consistent with well-established Kansas precedent, particularly in light of their indisputable standing to vindicate their own rights.

[17] The conclusion that Kansas law permits a properly-positioned plaintiff to assert claims on behalf of third parties with related claims/interests is not new or unique to the abortion context. Indeed, a number of cases have permitted a plaintiff to pursue such constitutional claims on behalf of others, in various contexts. See *e.g.*, *City of Wichita v. Griffie*, 318 Kan. 510, 516-517 (2024)(plaintiff had legal standing to pursue facial constitutional challenge to noise ordinance on behalf of both himself and all others similarly situated); *Kansas Bldg. Industry Workers Comp. Fund,* supra at 680 (trade associations had independent standing to commence claims on behalf of members that had claims, on an individual basis, even where the individuals were not required to grant complete relief); *NEA-Coffeyville v. Unified Sch. Dist. No. 445, Coffeyville, Montgomery Cnty.*, 268 Kan. 384, 387, 996 P.2d 821, 823–24 (2000) ("NEA–C, as the exclusive bargaining agent for the District's teachers, has standing to sue where the protection of teachers' rights is at issue."); *City of Wichita v. Wallace*, 246 Kan. 253, 267, 788 P.2d 270, 280 (1990) (business had standing to assert freedom of speech constitutional challenges for its customers); *DPR, Inc. v. City of Pittsburg*, 24 Kan. App. 2d 703, 707, 953 P.2d 231, 236 (1998) (plaintiff [business] "does have standing to raise issues involving the rights of third parties" in its constitutional challenge to a city ordinance).

4. Even if the Court were to go beyond Kansas' established standing requirements and evaluate "prudential" considerations, as it relates to their claims on behalf of patients, the Provider plaintiffs have demonstrated sufficient grounds to assert such claims.

While the State Defendants contend that the Provider plaintiffs lack legal standing because they seek to, in part, vindicate the rights of third parties and cannot satisfy the exception to this prudential self-imposed federal limitation, the flaw in their position is that ***Kansas courts*** have, to date, largely charted their own path with respect to the law of legal standing and have not specifically adopted other "prudential" limitations, above and beyond the well-established constitutional standards. See *Stubbs*, supra at 576 (calling "into question a court's reliance on federal prudential rules when resolving a party's standing in Kansas courts.").

In *Stubbs*, the Kansas Supreme Court steadfastly maintained the "independence [from federal courts] of our traditional two-part standing test." *Id.* (citing *Kan. Bldg. Ind. Workers Comp. Fund*, supra at 680, 359 P.3d 33 ("[g]iven the differences in the genesis of the two systems, we do not feel compelled to abandon our traditional two-part analysis as the definitive test for standing in our state courts.")). And notably, our highest court has, to this point, clearly stated that prudential standing requirements are "self-imposed judicial restraints" that "apply only to the exercise of federal courts' jurisdiction." *Id.* Consequently, these federal prudential limitations are, by and large, inapposite to an analysis of legal standing under Kansas state law. Our state's highest court has, to date, not expressly held that such considerations are determinative or applicable. *Id.* at 1219 ("we have never explicitly adopted a prudential standing doctrine, nor explained its role in a Kansas standing analysis."). This Court is duty bound to apply existing and binding precedent, as established by the state's appellate

courts, including its highest court. It is not generally free to apply standards that a party (or the Court) wishes were the law. Simply stated, the State Defendants' arguments regarding the federal prudential limitations on "third-party" standing are unavailing, in this Court's view, given current Kansas law.

Nonetheless, even if the Kansas Supreme Court had expressly considered, evaluated, and endorsed such considerations in the context of legal standing, the Court concludes that the Provider plaintiffs have more than satisfied the additional factors under prevailing prudential-standing analysis. First, there was substantial evidence presented at trial that the Provider plaintiffs have very intimate and close relationships with their obstetrical patients, including their patients seeking access to abortion. A physician-patient relationship is, indeed, the very definition of an intimate and close relationship, which often requires the exchange of the patient's most sensitive and private health information. And those encounters regularly require close personal physical contact between the provider and patient (e.g., physical examination, testing, and treatment). The record before the Court undeniably reflects an exceedingly "close" relationship between the Provider plaintiffs and their patients. See *Aid for Women v. Foulston*, 441 F.3d 1101, 1111-1114 (10th Cir. 2006) (citing *Kowalski v. Tesmer*, 543 U.S. 125, 130, 125 S.Ct. 564, 160 L.Ed.2d 519 (2004) and referencing authorities reaching same conclusions); accord *Singleton,* supra at *118* (plurality opinion) (noting the two-part test when asserting third-party standing and holding "that it is generally 'appropriate to allow a physician to assert the rights of women patients as against governmental interference with the abortion decision.'").

And, the Court has no problem concluding, on this record, that the Provider plaintiffs have interests that directly align with those of their patients that would otherwise seek to vindicate their natural and fundamental rights to determine whether to continue or terminate their pregnancy. Indeed, a pregnant woman that wishes to access abortion services simply cannot safely and realistically exercise her constitutional right without the assistance of a qualified licensed health care provider, such as the Provider plaintiffs. In that respect, both the Provider plaintiffs and their current and future patients that would seek to access abortion care share an interconnected interest in addressing and vindicating the rights necessarily implicated by the Subject Laws.

Further, there is no meaningful conflict, given this record, between the positions that the Provider plaintiffs espouse and those of their pregnant patients seeking abortion care, who would likewise seek to vindicate their rights to access abortion without governmental intrusion. This Court rejects the State Defendants' arguments that there is any inherent conflict, financial or otherwise, arising solely from the fact that the Provider plaintiffs ultimately charge their patients or other responsible parties for their services and care. In that regard, obstetrical physicians that provide abortion services are no different than any other provider of goods or services (including any other physician/health-care provider), and the mere exchange of pecuniary consideration to the providers for services rendered (or to be rendered) does not amount to a disqualifying "conflict," as the State Defendants would contend or as contemplated

under federal prudential case law.[18] See *e.g. Craig v. Boren*, 429 U.S. 190, 196 97 S. Ct. 451, 456 (1976) (beer vendors had standing to challenge gender-based liquor law on behalf of future customers); *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 106 S. Ct. 2169, 90 L. Ed. 2d 779 (1986), overruled on other grounds by *Planned Parenthood of Se. Pennsylvania v. Casey,* 505 U.S. 833, 112 S. Ct. 2791, 120 L. Ed. 2d 674 (1992) (invalidating certain portions of the Pennsylvania Abortion Control Act challenged by the American College of Obstetricians and Gynecologists); *Whole Woman's Health v. Hellerstedt*, 579 U.S. 582, 136 S. Ct. 2292, 195 L. Ed. 2d 665 (2016), as revised (June 27, 2016), and abrogated by *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 142 S. Ct. 2228, 213 L. Ed. 2d 545 (2022) (considering physician challenge to Texas abortion restrictions); *Kaahumanu v. Hawaii*, 682 F.3d 789, 788-89 (9th Cir. 2012) (business could challenge regulations on behalf of its clients); *Pennsylvania Psychiatric Soc. v. Green Spring Health Servs., Inc.*, 280 F.3d 278, 289-90 (3d Cir. 2002) (psychiatrists have a sufficiently close relationship with their patients to advance third-party claims); *DPR, Inc. v. City of Pittsburg*, 24 Kan. App. 2d 703, 953 P.2d 231 (1998) (bar had standing to assert customers First Amendment challenge to city ordinance).

Relatedly, there are undoubtedly emotional, practical, and logistical impediments and hindrances to the plaintiffs' individual patients vindicating their own rights, under the circumstances. First, the decision to have an abortion is, generally speaking, a highly-

[18] In fact, the Provider plaintiffs offer a wide range of services and care—including prenatal care and obstetrical care through delivery. The suggestion that they have some "financial incentive" and motivation to steer patients towards abortion that places them "at odds" with their patients is simply not supported by the record and appears more an *ad hominem* attack on those limited number of providers willing to offer such care, amongst the range of health care services they offer.

personal and private decision, as is most health care. That inherent quality is part and parcel of the natural and fundamental right to bodily autonomy. See *Hodes II*, 318 Kan. at 76-77 (noting the highly private nature of the patient's decisions in this context). But unlike many other types of health care, obstetrical care relating to abortion often comes with the well-documented and established potential for stigma, if the patient's choices, as it relates to continuing or terminating a pregnancy, are made public. That conclusion was abundantly clear from the evidence presented at trial. Thus, the Court has no doubt that many of plaintiffs' patients would be potentially "chilled" from exercising or advocating for their rights, if they were required to actively participate in public litigation as named plaintiffs in an effort to assert their fundamental right to make autonomous reproductive decisions, including the decision to terminate a pregnancy.

Further and importantly, the very nature of human pregnancy is temporally limited to approximately nine months. This biologic maxim creates inherent hindrances to an individual pregnant patient effectively pursuing, on her own, an ongoing and "live" claim regarding her fundamental right to bodily autonomy because of the relatively-short timeframe normally associated with human pregnancy. As such, pregnant patients are, in several respects, potentially ***less*** well-positioned than their treating physicians to act as proponents of their own independent pregnancy-related rights, which are inextricably related to their provider's own interests and rights (particularly their free speech rights, in this case).

This is because the individual patient's own actual or threatened injury could arguably be (and likely is under current precedent) considered "moot" long before final disposition of the litigation and before any individual pregnant woman is able to

vindicate her rights through the Courts. See *State v. Phipps*, 320 Kan. 616, 623, 570 P.3d 1240, 1248 (2025), reh'g granted, No. 125,269, 2025 WL 3966572 (Kan. Oct. 17, 2025) ("In other words, '[w]hen, by reason of changed circumstances between commencement of an action and judgment on that action, a judgment would be unavailing as to the issue presented, the case is moot.' ");[19] see also *Baker v. Hayden*, 313 Kan. 667, 490 P.3d 1164 (2021) (no actual or threatened injury endured after Baker received the recordings he sought); *Matter of Kukovich*, 385 P.3d 932, 2016 WL 7031851, *1 (Kan. Ct. App. 2016) (unpublished) (involuntary commitment challenge rendered moot because Kukovich was no longer involuntarily committed). Simply put, if a pregnant woman seeking to terminate her pregnancy were ***required*** to be the exclusive vindicator of such rights, it seems likely, under prevailing Kansas law, that her claims would be effectively "moot" after 22 weeks LMP (absent an emergency) because Kansas does not permit abortions after that date, and she would lose any ability to pursue the right thereafter.

Indeed, if "mootness" is a jurisdictional bar in Kansas, an individual patient's right to decide whether to continue or terminate a pregnancy is likely lost in Kansas, for all intents and practical purposes, after 22 weeks LMP (but certainly at the time of delivery—at or about nine months)--long before a trial on the merits of such claims

[19] It appears to this jurist that there is currently vigorous disagreement amongst the justices of the Kansas Supreme Court as to the nature and impact of "mootness" principles and whether they are rigid jurisdictional mandates or whether Kansas courts maintain some ability to review "mootness" using a more flexible and prudential framework to ensure important issues may be considered and decided, even if they may prove less of an immediate controversy between the named litigants. See *Phipps,* supra at 625-645 (Biles, dissenting) and (Standridge, dissenting); and note rehearing granted in *Phipps*. Nonetheless, *Phipps* is the most-recent pronouncement on these issues, and this Court is duty bound to consider and apply the likely ramifications of "mootness," as a jurisdictional bar, on the State Defendants' arguments that the plaintiffs' patients must be plaintiffs asserting their own rights.

could occur in the ordinary course of our justice system. Simply viewed as a function of human biology and Kansas' current statutory cutoff for abortion, when compared to the normal and expected timelines of civil litigation,[20] individual pregnant patients seeking to litigate and assert a constitutional right to bodily autonomy are certain to encounter hindrances, whether logistical, legal, and emotional, that likely do not exist as it relates to their health care providers, such as the plaintiffs herein. [21]

Conversely, the plaintiffs, as health-care providers for their patients, are more aptly situated to pursue not only their own claims of right but also the claims of their patients that are directly affected by the regulatory scheme at issue. The providers are effectively the targets of the Subject Laws, in that it is, by and large, their specific conduct and practices that the Legislature seeks to "regulate." As discussed below (see section IV.C, infra), the Provider plaintiffs assert their own constitutional rights, but the regulatory framework and requirements at issue and their attendant logical consequences also directly implicate their patients' respective constitutional rights. See generally *Hodes I, Hodes II, and Hodes III*; *Singleton*, supra at 118 (1976); *Aid for Women v. Foulston*, supra at 1111-1112. Their respective rights are inextricably linked, given the relationship, and the patients' rights are necessarily and directly at stake when adjudicating the Provider plaintiffs' own claims of right. The Provider plaintiffs

[20] Unsurprisingly, the instant litigation has been pending now for well over two years, as of the completion of trial.

[21] The Court does not mean to suggest that such practical, logistic, and/or emotional obstacles are universally insurmountable or prohibitive to a patient seeking to assert her own individual rights in this context. However, they are, nonetheless, very real and reflective of the type of considerations that merit, under prudential considerations, permitting a health-care provider, who is at least as well suited (if not better suited), to take up the mantle and advocate for both their own rights and those of their patients.

undoubtedly meet the exception to the federal prudential considerations and limits regarding third-party standing, if they were to apply to this case (they have not been adopted in Kansas to this point in time).

Simply stated, plaintiffs have standing to proceed—both on their own behalves and for their patients. The Provider plaintiffs, in their own right, easily satisfy the requirements for legal standing under Kansas law, as they have sufficiently demonstrated that they have and/or will suffer a concrete injury that is causally connected to the statutory schemes at issue. And, well-established Kansas case law reflects that our state courts have consistently permitted a plaintiff, such as a physician, to represent the interests of others where their rights are necessarily interconnected and at stake in the litigation commenced. See discussion, *supra* at 134-35 and n. 17. Moreover, the Provider plaintiffs further satisfy any "prudential" considerations and exceptions (if they were to be applied) to permit them to assert the rights of their pregnant patients (current and future), as it relates to the constitutional claims raised. Thus, the State Defendants' arguments as to plaintiffs' legal standing lack merit; the Provider plaintiffs have presented sufficient evidence to demonstrate valid legal standing under Kansas law.

B. The Subject Laws Violate Plaintiffs' Patients' Fundamental Natural Rights (Bodily Autonomy and the Right to Make Decisions Regarding a Pregnancy).

1. The analytic framework for constitutional review of these statutory enactments.

As a first step, the Court must determine the analytic framework for review of the Subject Laws. Kansas courts use a three-tiered approach or set of standards when

evaluating the constitutionality of a governmental restriction on an individual's rights. Namely, there is:

> "(1) the rational basis standard, which requires only that the legislative enactment bear some rational relationship to a legitimate state interest; (2) the heightened or intermediate scrutiny standard, which requires the enactment to substantially further an important state interest; and (3) the strict scrutiny standard, which requires the enactment serve some compelling state interest and be narrowly tailored to further that interest."

Hodes I, supra at 663. The nature of the right at stake and the individuals involved determines which of the three standards applies. *Id.* (citing *Farley*, 241 Kan. at 669, 740 P.2d 1058).

Generally, "[a] statute comes before the court cloaked in a presumption of constitutionality and it is the duty of the one attacking the statute to sustain the burden of proof." *Hodes I*, supra at 673 (citing *Liggett*, 223 Kan. at 616, 576 P.2d 221). When a statute is presumed constitutional, "all doubts must be resolved in favor of its validity. If there is any reasonable way to construe that statute as constitutionally valid, this court has the authority and duty to do so." *Miller v. Johnson*, 295 Kan. 636, 646-47, 289 P.3d 1098 (2012).

However, a far more demanding burden falls upon the State in cases involving either suspect classifications or fundamental rights. *Hodes I*, supra at 673. If a plaintiff demonstrates that a challenged law infringes upon a constitutionally protected fundamental right, the District Court must apply strict scrutiny. This heightened level of review applies where there is "[a]ny degree of actual infringement—however slight". *Hodes II*, supra at 1005; *Hodes I*, supra at 669 (holding infringement, regardless of degree, triggers strict scrutiny). In such circumstances, courts **must**:

> "***peel away the protective presumption of constitutionality and adopt an attitude of active and critical analysis, subjecting the classification to strict scrutiny***."

Hodes I, supra at 673 (citing *Liggett*, 223 Kan. at 617, 576 P.2d 221) (emphasis added). Towards that end, "the burden of proof is shifted from plaintiff to defendant/State and the ordinary presumption of validity of the statute is reversed." *Id.*; *Farley*, 241 Kan. at 670, 740 P.2d 1058. This burden shift stems from the recognition that government infringement of a fundamental right is inherently suspect. *Hodes I* supra at 673. Consequently, in such a burden-shifted analysis, a trial court must engage in a "searching judicial inquiry" to "smoke out 'illegitimate' governmental action by ensuring that the State is pursuing a specific goal "important enough to warrant use of a highly suspect tool." *Id.* at 673-74 (citations omitted).

The parties essentially agree on these basic analytic principles. However, they disagree vehemently as to how the analysis applies to the facts of this case. See Index No. 630; Pretrial Order. Provider plaintiffs contend that the Subject Laws infringe upon fundamental constitutional rights and consequently, strict scrutiny applies—shifting the burden to the State Defendants to demonstrate validity. The State Defendants disagree, instead contending: 1) that the Subject Laws are either subject to "rational basis" analysis because they do not infringe upon fundamental rights, or 2) if they do so infringe, they survive strict scrutiny because they are narrowly tailored to effectuate what they assert are any number of "compelling" governmental interests.

Having heard and analyzed the extensive evidence presented at trial, the Court concludes that strict scrutiny applies.

2. Strict scrutiny applies to state regulation that infringes on a fundamental right.

Section 1 of the Kansas Constitution's Bill of Rights, which was enacted and ratified in 1859, provides:

> "All men are possessed of equal and inalienable natural rights, among which are life, liberty, and the pursuit of happiness."

Equal rights, KS CONST B. of R. § 1. Significantly, this language varies from the language of the Fourteenth Amendment to the United States Constitution, which had historically (prior to the *Hodes I* decision) been viewed by Kansas appellate courts to be coextensive with the protections and analysis required in Kansas.

This distinction is significant, because in 2019, the Kansas Supreme Court recognized the fundamental and natural right to personal/bodily autonomy that inures to all Kansans and those within its borders. *Hodes I*, supra at 680. It concluded that the right to control one's own body, to assert bodily integrity, and to exercise self-determination was a natural right and was fundamental—thus entitled to protection by Section 1 of the Kansas Constitution's Bill of Rights. *Id*. at 660, 680. This right is separate, distinct, and broader than the protections contemplated under the United States' Constitution. *Hodes I*, supra at 624. The Court, in *Hodes I* and in subsequent decisions, confirmed that a woman's fundamental right to bodily autonomy, equal to that of a man's, encompasses the right and ability ***to make her own decisions*** regarding her body, health, family formation, and family life—**including the right to either continue or terminate a pregnancy**. See *Id.* at 680*;* see also *Hodes & Nauser, MDs, P.A. v Kobach,* 318 Kan. 940, 950 (2024) (hereinafter *Hodes II*) (reaffirming holding of

Hodes I); *Hodes & Nauser, MDs, P.A. v. Stanek,* 318 Kan. 995 (2024) (hereinafter *Hodes III*) (same).

Kansas law, then, requires that this Court apply strict scrutiny to any state law or regulation that infringes upon a woman's bodily autonomy, including the right to terminate a pregnancy. *Hodes I* at 671. ***Any*** infringement, "regardless of degree," leads to a presumption that the government's action is unconstitutional. *Id.* at 669, 673-74. Accordingly, the State may not legislate so as to infringe upon such a right, unless it thereafter demonstrates a "compelling governmental interest" that is, in fact, advanced by the regulation and that is "narrowly tailored" to achieve that interest. *Id.* In that regard, a "compelling interest" is one that is "'not only extremely weighty, possibly urgent, but also rare—much rarer than merely legitimate interests and rarer too than important interests.'" *Hodes I,* supra at 663 (citation omitted). Narrow tailoring contemplates that the governmental action is accomplished in the least restrictive means and is neither overbroad nor underinclusive. *Id.*; see also *Hodes II*, supra at 954-55.

3. The WRTKA infringes upon and impairs pregnant women's rights to bodily autonomy.

Plaintiffs have more than adequately demonstrated that the Subject Laws actually infringe, not only upon their fundamental constitutional rights (discussed below, see Section IV.C, infra), but also upon those natural and fundamental rights of their pregnant patients seeking to exercise their bodily autonomy. The WRTKA does this by compelling these healthcare providers to communicate messages they otherwise would not and by conditioning otherwise legal healthcare on arbitrary delays, invasive questioning, and voluminous repetitive disclosures of dubious value.

The WRTKA (including the APR Mandate, which supplements and is part of the WRTKA), infringes upon the plaintiffs' patient's rights to bodily autonomy, as guaranteed by Section 1 of the Kansas Constitution's Bill of Rights, in at least three ways. The evidence of infringement presented at trial was overwhelming in this regard.

First, the WRTKA requires multiple non-discretionary delays, whether of twenty-four hours (written disclosures, pursuant to K.S.A. 65-6709 (a), (b), (d)) or, in other provisions, thirty minutes (in person hold and consult with the actual service provider—K.S.A. 65-6709(c); ultrasound hold—K.S.A. 65-6709(h); heart monitor hold—K.S.A. 65-6709(i)), following receipt of mandatory information that the State considers germane.[22] See FOF ¶¶22-23, 25-27, 34. These compulsory delays exist regardless of the decisional certainty held by the pregnant women and regardless of the provider's professional judgment that there is no reason the procedure cannot proceed before the expiration of the statutory waiting periods. FOF ¶¶154-56, 176-77, 216, 228, 291. Patients have had desired care delayed or, in some cases, entirely denied because of the mandatory WRTKA waiting periods. FOF ¶¶174-91. Delayed or denied care that a patient is otherwise legally entitled to is a classic example of a law that ***actually infringes*** on an individual patient's fundamental right to bodily autonomy.[23] FOF

[22] This includes the APR Mandate, which requires a 24-hour waiting period that follows the provision of those additional mandatory disclosures.

[23] This infringement of a woman's right to autonomy exists universally under the WRTKA, regardless of whether some hypothetical subset of pregnant women might not take exception to the obligatory statutory delays and disclosures. In other words, under the Act, every pregnant woman contemplating an abortion has their rights impaired, regardless of either the State's or the woman's perception of the Act's alleged utility.

¶¶190-93, 291. See *Hodes I*, supra at 672; *Hodes III*, supra at 1011 ("restrictions that merely delay access to abortion impair a fundamental right" to abortion.)

But the WRTKA goes beyond mere delays. It requires a pregnant patient to navigate a *labyrinth* of procedural hurdles prior to, and as a condition of, obtaining the care she desires. The WRTKA requires a mandatory "informed consent" form to be on certain paper,[24] in certain color, in certain font, and reflecting the WRTKA's substantive disclosures. The WRTKA further requires (under threat of professional discipline) providers to obtain the patients' certification that the form and information, in its particularized profile, was received, reviewed, executed, and returned by the patient in conformity with the Act's requirements, prior to and conditionally a precedent to, a patient's care. FOF ¶¶ 21-29, 72, 174-191, 223, 228, 291. The WRTKA requires strict compliance with the entire process, and a healthcare provider (such as plaintiffs) is prohibited from legally proceeding, and he/she risks administrative, civil, and/or criminal consequences, absent compliance . FOF ¶¶ 6-7, 21-38. These draconian processes, which have "ballooned" over time and exist in no other articulated healthcare context in Kansas, have resulted in emotional trauma and stress for plaintiffs, their staff, and their patients, and it causes delays and/or denials of care when the precise logistics and requirements are not explicitly followed. See FOF ¶¶ 10-31, 48-49, 174-92, 291.

[24] The evidence presented at trial reflected that these "informed consent" documents required by the existing WRTKA are often emailed or provided via a current electronic "link" by the plaintiffs to the patient for them to use and print out for execution and transmission in accordance with the WRTKA mandates. See e.g., FOF ¶¶72; 74-75, 180-90; see also testimony of Nauser, Ranney, Wales, and Huntington. However, the ultimate formatting requirements are, at most, a smaller (yet significant) part of the ultimate obstacles to care (and to a pregnant woman's exercise of her fundamental rights) that the WRTKA presents through its mandatory waiting periods and overarching and invasive processes.

The argument that these delays and processes are "reasonable" and do not amount to an actual denial of patients' rights, rings hollow when held to the "any infringement, regardless of degree" standard that Kansas law demands. Simply put, the WRTKA delays and denies care, and in doing so, it infringes upon the fundamental rights of pregnant women, including plaintiffs' patients, to exercise bodily autonomy with respect to their pregnancies. See *Hodes I*, supra at 672; *Hodes III*, supra at 1011.

Furthermore, a part and parcel to the right of "bodily autonomy," as contemplated and prescribed by *Hodes I,* is the right of pregnant women to assert "self-determination" and "make their own decisions" —free of governmental interference that runs counter to the professional judgment of their trusted and personally-selected health care provider. The WRTKA invades and violates that fundamental right to autonomy/self-determination by injecting the State's preferred spiritual, moral, and/or ideologic perspective on abortion and pregnancy decisions into the confidential and exceedingly personal decision-making process. The WRTKA's mandates are antithetical to and a significant encumbrance on a woman's right to self-determination regarding her reproductive future. If that self-determination is to mean anything, it must involve the right of a woman to independently consider the germane, accurate, medical information with the assistance of a trusted health care professional, without the government's figurative presence and mandated counsel at her health-care bedside, especially on such deeply personal issues, absent a demonstrated compelling need. *Hodes I*, supra at 663 (compelling interests are "rare."). This is particularly true at the earlier stages of pregnancy—such as the period during which abortion is expressly permitted in Kansas (pre-viability/prior to 22 weeks LMP). Plaintiffs have brought forth substantial and

compelling evidence that the WRTKA further infringes on the fundamental rights of pregnant women contemplating terminating their pregnancies due to this substantial interference in the independent self-determinative decision-making process.

Relatedly, while the medical relevance, accuracy, and import of the WRTKA's substantive disclosures is contested by the State, this Court has no doubt that the Provider plaintiffs presented far-more compelling testimony and evidence on these issues. The WRTKA requires disclosure of a litany of state-sponsored statements, many of which were demonstrated at trial to be scientifically inaccurate and/or misleading. See FOF ¶¶ 10-29, 32-38, 76, 83, 194-217. Several witnesses, including Dr. Nauser, Dr. Wynia, Ms. Wales, and Dr. Alsadan, persuasively articulated why much of the data mandated by the WRTKA was neither material nor helpful to most of their pregnant patients; indeed, the opposite appears to be true. See FOF ¶¶ 71, 73-4, 76-7, 194-228, 291. The Provider plaintiffs universally testified that they would not provide the required disclosures, absent these legislative mandates. FOF ¶ 205-206, 227-228, 290. They further testified that at least part of the WRTKA requirements (the APR Mandate) so violates their ethical duties to their patients that they would rather stop providing medication abortions altogether than communicate the State's message. FOF ¶¶ 206, 225. This is because of their conviction that the information is not only scientifically unfounded and misleading but also dangerous to their pregnant patients' health and

safety.[25] FOF ¶¶ 194-215, 219-222, 226-27.

The uncontroverted evidence on this from plaintiffs ultimately reflects yet another reason why the WRTKA and APR Mandate actually infringe upon a woman's fundamental rights. Our Supreme Court has already concluded and held that restrictions that "threaten the already small number of providers willing to perform" an abortion equally impairs a person's natural and fundamental rights. See *Hodes I*, supra at 672. Threats of disciplinary action, criminal charges, and/or civil liability, absent compliance, pursuant to the WRTKA and the additional "bounty hunter" provisions (K.S.A. 65-6716 (h)) of the APR Mandate, which supplements the WRTKA, are likely to chill practitioners from engaging in non-conforming and traditional standard-of-care treatment. Plaintiffs' express testimony that their safety concerns resulting from compliance with portions of the WRTKA (APR Mandate) would lead them to simply stop providing the desired care unquestionably rises to the level of infringing or impairing their patients' fundamental rights, as contemplated in *Hodes I* and *Hodes III*. It would reduce the already small number of providers willing to offer the desired care, particularly for the most prevalent method of abortion in Kansas—medication abortion using Mifepristone and Misoprostol. See FOF ¶¶ 129, 225-26.

[25] Notably, identical or nearly-identical statutory language has been introduced and promulgated in a number of other states; however, in not one state where the language has now been challenged (as far as the Court has discerned from its research) did such statutory mandates pass constitutional muster—either under a state or federal analysis. The Court takes judicial notice of these cases and those Court's rulings and finds the conclusions and holdings of import. See *American Medical Ass'n v Stenehjem*, 412 F.Supp.3d 1134 (D. N.D. 2019) (finding medication abortion "reversal" statute likely facially unconstitutional under the U.S. Constitution and entering preliminary injunction); P*lanned Parenthood of TN and N. Miss. v. Slatery,* 523 F.Supp. 985 (M.D. Tenn. 2021) (holding the same as it relates to an identical Tennessee statute); *All-Options, Inc. v. Attorney General of Indiana*, 546 F. Supp. 3d 754 (2021)(same); *Planned Parenthood of Montana v. State*, 409 Mont. 378 (2022) (same under state constitution); see also *Ntl Inst. Of Fam. & Life Advoc.(NIFLA) v. Bonta*, 769 F.Supp.3d 1109, 1122-29 (C.D. Cal. 2025)(finding APR theory was "inherently false and misleading").

Coopting the normal informed-consent process with significantly inaccurate, incomplete, misleading, unethical, and/or irrelevant information further impermissibly interferes with and infringes upon a pregnant woman's right to hear and consider germane and scientifically-accurate data from her trusted health-care professional, so as to make *her own choice* on pregnancy. *Hodes I,* supra at 680 ("personal autonomy, [ ] includes the right to control one's own body, to assert bodily integrity, and to exercise self-determination. This right allows a woman to make her own decisions"); see also FOF ¶¶186, 191, 216-22, 227-28. And the WRTKA dilutes the significance of the important information necessary for actual "informed consent," in the interests of requiring the repeated communication, in multiple forms and fashions, of the desired and state-mandated perspectives and preferences. FOF ¶¶ 216-28. In doing so, the WRTKA undermines and actually interferes with the patient's right to make autonomous decisions regarding "their bodies, their health, their family formation, and their family life." *Hodes I* at 660. It renders any consent less informed—not more.

4. The Reason Mandate infringes upon and impairs pregnant women's right to bodily autonomy.

Similarly, the Court concludes that the Reason Mandate, as written, infringes upon pregnant women's rights to bodily autonomy. This includes plaintiffs' current and future patients. The Reason Mandate requires that abortion providers ask each pregnant patient, ***prior to*** administering the health care sought, to identify the "most important reason" why she wants to terminate her pregnancy from a list of eleven (11) predetermined "reasons." The "reasons" themselves are not innocuous—they are legislatively pre-determined, emotionally-charged, and appear designed to shame or re-traumatize patients. FOF ¶¶40-49, 229-284. Forcing women to formulate the

"reasons"—whether they decide to identify one or not[26]—as a condition precedent to care is no less an infringement on the right to exercise bodily autonomy because it requires them to endure potentially-triggering, stigmatizing, and *mandatory* inquiries ***before*** they may exercise their choice and decision. See *Hodes I*, supra at 672 ("any infringement" or "impairment" standard for this very personal decision and right); *Hodes III*, supra at 1011 (same).

The Reason Mandate additionally requires that providers ascertain:

1. whether, in the 30 days prior to the abortion, the patient received services, financial assistance, excluding financial assistance in obtaining an abortion, or other assistance from a nonprofit organization that supports pregnant women;

2. whether the patient reported having experienced domestic violence in the 12 months prior to the abortion;

3. whether the patient is living in a place that the patient considers to be safe, stable and affordable."

FOF ¶ 40-42.[27] There is no ability for either the patient to decline to respond to such additional inquiries or the provider to decline to ask these questions, based upon his/her professional judgment. FOF ¶41. Regardless of whether such questioning may mentally or emotionally harm these patients (particularly regarding prior intimate partner violence

[26] The Reason Mandate does appear to permit a patient to listen to the "most important reason" question and the eleven pre-ordained potential responses and then decline to answer; however, there is no such declination option for the additional inquiries that are, actually, conditions to the receipt of the health care (i.e., "financial assistance," twelve-month history of domestic violence," or "stable housing"), which must be affirmatively addressed, regardless of either the patients' desires to consider and respond or of the provider's judgment as to the advisability of such a discussion. And, as discussed in greater detail below, such laws cause stigmatization of patients, which results in various adverse impacts on the patient. This stigmatization further impairs the exercise of a woman's right to autonomy.

[27] These new statutory obligations are above and beyond the historical ITOP data that is considered routine, non-invasive, and non-controversial public health surveillance of basic demographics (age, residence, race/ethnicity, stage of pregnancy, etc.). FOF ¶¶232-54.

incidents during the prior 12 months) and whether it may undermine their trust in their provider and/or their willingness to further engage with health-care providers, the plaintiffs are legally obligated to comply with the State's questioning during a patient's health-care visit and decision-making process, as a **condition precedent** to such care.

Taken together, and in light of the impact on existing practices under the applicable professional and common-law standard of care, the Court concludes that the Reason Mandate also infringes upon the fundamental and natural rights of pregnant women, including plaintiffs' patients. The Reason Mandate would, at the very least, delay desired care by additional mandatory interrogation of this relatively-small set of Kansas patients with stigmatizing questioning. See FOF ¶¶ 40-42, 48-49. Indeed, the State ultimately seeks to hijack the providers' professional interactions and create a "captive audience"[28] to obtain sensitive information ("most important reason," domestic violence, secure housing, financial assistance). And it does so using a format likely to generate negative emotional and mental health responses, retraumatize certain patients,[29] and undermine patient trust in the confidential fiduciary relationship with their providers, who are not permitted, by the plain statutory language, to exercise any professional judgment or discretion to omit discussion of such matters. FOF ¶¶ 41-42,231, 267-69, 272-77, 280-84. The evidence at trial demonstrated that the Provider

[28] "captive" in the sense that, under the Act, pregnant women must listen to and, for many of the inquiries, respond with substantive information, if they wish to proceed forward with their desired care.

[29] Certainly, victims of rape, incest, and domestic violence are, not uncommonly, unwilling or unable to discuss these situations even with family, friends, or trusted professionals. Requiring health care professionals to universally inquire of their patients, potentially in close proximity to such trauma, whether such traumatic occurrences are the "most important reason" for their decision to terminate their pregnancy seems reasonably likely to require the patient to contemplate and potentially re-live such experiences and can result in the patient feeling compelled to answer—even when they have not otherwise previously disclosed such information, for whatever their personal reasons may be.

plaintiffs were opposed to these statutory interrogations, as potentially harmful and unnecessary—with little, if any utility, and it was uncontroverted that they would not normally engage in these inquiries, universally, absent a statutory mandate. FOF ¶272. These negative repercussions of the interrogations are likely to further result in a correspondingly-negative impact on the patient's willingness and/or desire to further engage in the healthcare that they seek (or other healthcare) and on the very essence of their confidential relationship with their providers. See FOF ¶¶ 277, 280-84. Thus, it further infringes on pregnant women's fundamental rights to make truly autonomous decisions regarding their bodies, their pregnancies, and their future family structures.

One might reasonably ask of the Subject Laws: to what end? As discussed in greater detail below, the State Defendants' evidence is grossly inadequate to answer such questions in a constitutionally-sufficient way and, thus, to justify such infringements.

5. The State Defendants have failed to demonstrate that the Subject Laws pass muster under a strict-scrutiny standard.

a. The State Defendants have failed to adequately show any compelling state interest that was contemplated when enacted and that is furthered, in fact, by the Subject Laws.

Strict scrutiny shifts the burden of proof to the State to justify a presumptively suspect legislative scheme. See *Hodes I*, supra at 663-64; *Hodes II*, supra at 950-51. Towards that end, the State must demonstrate the existence of a "compelling" governmental interest motivating the statutory scheme at issue and that the regulatory enactment addresses an existing, urgent, and rare problem at the time of passage. See *Id*.; see also *Hodes III*, supra at 1017-1019. Yet, it is not enough to merely articulate a

constitutionally-permissible interest/reason for acting; the State must also demonstrate its goals/interests are, in fact, achieved in a narrowly-tailored way, reflective of the least restrictive means. *Hodes II,* supra at 954; *Hodes III*, supra at 1015.

In Kansas, a "compelling" governmental interest is "one that is 'not only extremely weighty, possibly urgent, but also rare—much rarer than merely legitimate interests and rarer too than important interests." *Hodes I*, at 663; *Hodes II* at 951-952; *Hodes III* at 1015. Further, broad, aspirational, or generic "interests," which are susceptible to *post-hoc* justifications, are unlikely to qualify as "compelling." See *Hodes II* at 958-59. Instead, "compelling" interests should be "concrete and exhibit some level of specificity, rather than [being] broad and open to wide interpretation and inclusion of a great array of concerns." *Hodes II*, supra at 952. Such rationales must not be "generic" or amount to little more than a "commendable goal," as judicial review of such justifications becomes elusive, if not impossible. *Id.*

This sentiment comports with well-established federal precedent[30] implicating heightened-scrutiny analysis when fundamental rights are at issue. Indeed, the United States Supreme Court has held that:

> "The justification must be genuine, not hypothesized or invented post hoc in response to litigation. And it must not rely on overbroad generalizations . . . ."

U.S. v. Virginia, 518 U.S. 515, 533, 535-36 (1996) (in equal protection context) ("VMI decision"). Although the *VMI* decision involved intermediate scrutiny under a federal equal protection analysis, the same requirements hold true under strict scrutiny.

[30] While these federal cases are not binding on the Court, given the issues presented, the analysis and requirements as to what is required to satisfy the "compelling interest" component of strict scrutiny is generally helpful, in light of the Kansas Supreme Court's holdings in *Hodes II* (set forth above).

Indeed, it would be peculiar to require less from the State under a more rigorous analytic framework.

Overly general statements of abstract principles similarly do not satisfy the government's burden to articulate a compelling interest. For example, in *Brown*, the Supreme Court insisted that "[t]he State must specifically identify an actual problem in need of solving...." *Brown v. Entm't Merch. Ass'n*, 564 U.S. 786, 799, 131 S.Ct. 2729, 2738, 180 L.Ed.2d 708 (2011) (quotations omitted). Also, in *Watchtower Bible, Tract Society of New York, Inc. v. Village of Stratton*, 536 U.S. 150, 122 S.Ct. 2080, 153 L.Ed.2d 205 (2002), the Court rejected the government's asserted general interest of crime prevention in part because "there is an absence of any evidence of a special crime problem related to [the challenged discriminatory law] in the record before us." *Id.* at 169, 122 S.Ct. 2080.

The Tenth Circuit agrees, noting that "[f]or an interest to be sufficiently compelling to justify a law . . . ., the interest must address ***an identified problem*** that the discrimination seeks to remedy." *Awad v. Ziriax*, 670 F.3d 1111, 1129 (10th Cir. 2012) (citing *Brown,* supra) (in context of First Amendment challenge) (emphasis added). The government must identify ***an actual concrete problem*** because "[m]ere speculation of harm does not constitute a compelling state interest." *Consol. Edison Co. of New York, Inc. v. Pub. Serv. Comm'n of New York*, 447 U.S. 530, 543, 100 S.Ct. 2326, 65 L.Ed.2d 319 (1980); see also T*urner Broadcasting Sys., Inc. v. FCC*, 512 U.S. 622, 644, 114 S.Ct. 2445, 129 L.Ed.2d 497 (1994) (plurality) ("[The government] must demonstrate that the recited harms are real, not merely conjectural, and that the regulation will in fact alleviate these harms in a direct and material way.").

And Kansas law requires, under a strict-scrutiny analysis, that the State not only demonstrate and establish a compelling governmental interest but also that the statutory scheme involved ***actually furthers*** that ***specific interest.*** See *Hodes I*, supra at 696; *Hodes II*, supra t 953; *Hodes III*, supra at 1018-1019; see also *Whole Woman's Health v Hellerstedt*, 579 U.S. 582, 627, 136 S.Ct. 2292 (2016) (noting the lack of evidence showing that the legislation at issue furthered the State's interest and concluding that the record was, thus, insufficient to survive strict scrutiny); *Ernest v Faler*, 237 Kan 125, 138 (1985) (statute unconstitutional because no real or substantial relationship to the government's interest). Indeed, "[s]howing that its action furthers its asserted interest can be crucial to the government's success." *Hodes II*, supra at 953.

In light of these guiding principles, as part of its searching judicial inquiry using active and critical analysis, the Court turns now to the State's proffered governmental interests.

i. *The State Defendants have asserted myriad "interests," including several that are mere* post-hoc *rationalizations or are broad and generic aspirational goals, rather than governmental interests reflective of concrete problems motivating the enactment of the Subject Laws.*

The State Defendants assert that the Subject Laws are permissible, based upon, and motivated by, a litany of purported governmental "interests." However, the Court concludes that several of the identified interests are simply *post-hoc,* manufactured, and generic justifications that cannot qualify, in hindsight, as "compelling interests" under a strict-scrutiny analysis. Thus, this Court must reject such arguments and "interests."

The State Defendants identified the following "interests" underlying the Subject Laws, in the Pretrial Order:

a. enhancing women's right to autonomy;
b. safeguarding maternal health and safety;
c. protecting the vulnerable from coercion and abuse;
d. upholding the integrity in the medical profession;
e. alleviating abortion-related regret;
f. minimizing fetal pain; and
g. promoting, protecting, preserving, and respecting fetal life.

Pretrial Order, Index No. 630; pg. 28, Section 7. State Defendants' subsection V.

Notably, interests in paragraphs a. ("enhancing women's autonomy"), c. "protecting the vulnerable from coercion and abuse"), and e. ("alleviating abortion-related regret"), given the trial record, appear clearly improper *post-hoc* litigation-related arguments—as opposed to contemporaneous concerns regarding an existing problem that the legislature sought to address. The evidence before this Court does not indicate that such "interests" existed at the time these laws were enacted and were, even in part, motivations or known considerations underlying the Subject Laws. Ms. Pond, Ms. Cole, and Ms. Hoyle's testimonies about their procedural abortions—some of which were performed out-of-state and all of which occurred decades before the WRTKA—do not reflect a *contemporaneous* legislative concern with or interest regarding women's autonomy, protecting vulnerable populations, or alleviating regret when the WRTKA was first enacted, much less when subsequently amended. Further undermining their effort, the State Defendants presented no credible evidence that Kansas' current legal frameworks relating to abortion creates, exacerbates, or fails to address some "rare and urgent" concern that falls within their post-enactment trial arguments on such purported interests.

If women's autonomy, protecting vulnerable populations, and/or alleviating regret really were top-of-mind for the Legislature, logic would suggest that the State

Defendants would have consistently asserted such interests from the get-go. And yet, they did not. Indeed, the State Defendants appear to first meaningfully identify such "interests" in the Final Pretrial Order. Compare State Defendants' Answer and Twenty-Third Affirmative Defense; Index No. 220, and State Defendants' briefing on Temporary Injunction, Index No. 53, with Pretrial Order, Index No. 630; pg. 28, Section 7. State Defendants' subsection V (identifying seven purported interests, including women's autonomy, protecting vulnerable populations, and alleviating regret).

Such after-the-fact rationalizations by counsel simply cannot rise to the level of a compelling governmental interest under strict scrutiny and must be rejected. See *Hodes II*, supra at 956, 959 (governmental arguments must rely upon "actual evidence" and not upon "generic" interests that can justify just about anything it would want to do); see also *VMI*, supra at 533, 535-36; *Awad v. Ziriax*, supra at 1129. There was no nexus between State Defendant's evidence at trial and *any* legislative knowledge or intent/motivation as to these interests, which is required under strict scrutiny. This glaring disconnect in the State Defendants' case simply highlights the *post-hoc* nature of their justifications and position.

Furthermore, the Court expressly rejects the purported interest raised by the State Defendants relating to "enhancing women's right to autonomy" for any number of additional reasons. As discussed, there was no affirmative credible evidence presented by the State Defendants that the Subject Laws were intended by our legislature to address some (indeed, any) existing problem relating to Kansas women's lack of "autonomy" at the time the WRTKA was enacted or substantively amended (including the APR Mandate) or at the time of enactment of the Reason Mandate. It again smacks

of the State Defendants' attempting to engage in generic *post-hoc* rationalizations by simply parroting language from *Hodes I* and its progeny. This appears to be in lieu of actual contemporaneous evidence of the legislature's intent and/or motives, in response to an actual and existing problem. Such a broad brush "aspirational goal" of "enhancing autonomy" could mean whatever the State Defendants now want it to mean, rather than reflecting our legislature's actual motivation, grounded in evidence or plain statutory language, for enacting a statutory solution to an existing problem at or prior to enactment. Bodily autonomy is not merely a glittering aspirational goal but a fundamental right guaranteed by our state's Constitution, and it must be analyzed as such.

The State Defendants' argument regarding "enhancement" to women's autonomy as a true legislative interest seems virtually impossible to argue with a straight face, though the State Defendants have done so, unconcerned with such matters. The legislative mandates of the WRTKA dictate that abortion providers delay a pregnant woman's desired course of care and, as part of the process, overwhelm those patients with pages upon pages of State-sponsored "facts,"—significant portions of which were persuasively demonstrated to be inaccurate, medically immaterial, and (in some respects) dangerous/harmful for women. FOF ¶¶ 76, 83, 194-208, 213, 215, 217, 219-22, 228. Such a mandatory process is, by definition, the exact opposite of a process that "enhances" ***self-determination and autonomy.*** Instead, it reflects, by and large, the State's preferred message and preferred decision/outcome and is driven exclusively ***by the State*** and not the patient, in conjunction with their chosen trusted professional exercising his/her professional judgment and discretion. FOF ¶¶ 217-22, 285, 288-91.

It in no way "enhances" autonomy, given the dictates; instead, it seeks merely to persuade.

The purported "interest" of "enhancing" women's autonomy fares no better in the context of the Reason Mandate. First, there was an absence of credible evidence presented that the motivation of "enhancing autonomy" existed and was a contemplated goal of that particular statutory scheme, even if it were something other than a broad, aspirational statement. FOF ¶¶ 39-49, 250-256, 271. The exact opposite appears true. At the time of debate and passage one of the supporting state legislators for H.B. 2749 declared: "We want to make sure ***we're making the right decision for*** these women." See FOF ¶ 252; see also Plaintiffs' Exhibit 11 (emphasis added).[31] The irony of the State Defendants' position that state-mandated messaging and dictating of the timing and sequence of specific reproductive healthcare furthers the patient's own "autonomy," is not lost on the Court. Consequently, the Court also rejects this asserted "interest" in "enhancing women's autonomy" as uncompelling (from a strict-scrutiny standpoint) on its face, with respect to the Reason Mandate (and more broadly with respect to all the Subject Laws), but also as lacking specificity, legitimacy, credibility, or as, in fact, advancing the government's asserted interest, given the record adduced at trial.

Having dispensed with several of the State Defendants' purported interests that allegedly underlie and justify the Subject Laws, the Court now turns to the remaining interests articulated by the State throughout the pretrial process and at trial.

[31] The House Journal also reflects a statement by proponents that "understanding women's reasons for having abortions can inform public debate and policy regarding abortion and unwanted pregnancy." Plaintiffs' Exhibit 11. However, this too does not appear to reflect any obvious nexus to the State Defendants' manufactured "goal" of "enhancing [pregnant women's] autonomy."

ii. ***<u>In this case</u>, maternal health/safety is not a compelling interest that is, in fact, furthered by the Subject Laws.***

The State Defendants' asserted interest in promoting/safeguarding maternal safety, health, and/or well-being ("maternal health and safety"), simply does not rise to the level of a "compelling" state interest, as it relates to the Subject Laws. *In theory*, this "interest" could be academically legitimate (and even potentially important or compelling) in an appropriate circumstance. But the Court concludes, in this case, that this asserted interest falls short of a "compelling" interest, as it relates to the Subject Laws.

First, as it relates to the WRTKA, the record before the Court is devoid of any existing or concrete problem that motivated, in fact, the enactment of the WRTKA (including the APR Mandate) to further "maternal health and safety." The State Defendants wholly failed to demonstrate any credible evidence of an existing significant problem or concern regarding the sufficiency of existing informed consent practices (or a corresponding maternal health problem resulting from the traditional informed consent discussions conducted in accordance with the applicable professional standard of care), either generally or more specifically with plaintiffs—who are amongst the limited number of health-care providers that offer abortion services in Kansas. See FOF ¶¶ 293-95. Indeed, the evidence was that the plaintiffs did not have any prior history of lawsuits, complaints, or violations, with respect to informed consent, much less issues ultimately implicating maternal health and safety. FOF ¶157. Nor was there credible evidence of any broader problem within the abortion context creating some notable and urgent health or safety risk to pregnant women. The opposite was overwhelmingly demonstrated at trial. FOF ¶¶ 96, 136, 139-142, 154-58, 293-95. Abortion is, generally

speaking, extremely safe, effective, and not uncommon. FOF ¶¶ 136-42, see also Plaintiffs' Ex. 68, pg. 10; Plaintiffs' Exhibit 69, pg. 1. Such procedures in Kansas and nationally are overwhelmingly performed during the first 22 weeks LMP, and the uncontroverted evidence was that risks to a pregnant woman's health and safety significantly increased throughout the term of a pregnancy. FOF ¶¶ 9, 126, 296; see also Exhibit 68, pg. 5; Exhibit 69, pg. 1. Consequently, childbirth and term pregnancy present far greater risks to a pregnant woman than does undergoing an abortion in Kansas during the generally permissible temporal limits. FOF ¶ 136-42, 296. In short, the record *in this case* is devoid of the type of "rare," "extremely weighty," and/or "urgent" problem/concern regarding "maternal health or safety" that the WRTKA was aimed at addressing at any point during its existence. The State Defendants failed to demonstrate that maternal health and safety concerns warrant the WRTKA's provisions. Put plainly, the interest is not compelling in this case, and objectively evaluated, the WRTKA is a solution in search of a problem.

The State Defendants have similarly failed to support the Reason Mandate as having been motivated by a "compelling" state interest in "maternal health and safety." In fact, the uncontroverted evidence at trial indicated that the state agency responsible, in large part, for implementation and maintenance of the proposed data collection under the enacted Reason Mandate (the KDHE) was ***never consulted*** regarding the presence or absence of a concrete urgent problem, the proposed legislative scheme, or its substantive intent or process to correct any perceived problem. See Pls.' Dep. Desigs. vol. 2, Ex. C, Lara (KDHE) Dep. 28:18-29:6 (May 19, 2025); FOF ¶¶ 46, 252. Nor is there any indication that KDHE either had (at the time of enactment) or currently

has any use or anticipated value for the materials to be gathered under the scheme. FOF ¶¶ 253-54, 269. And conclusory legislative statements suggesting that changes in "demographics" create a "need" (See Exhibit 11) for an involuntary and unscientific data collection falls woefully short of constituting the type of "rare" or "urgent" problem justifying an infringement on a woman's fundamental constitutional rights. This is particularly so when it is solely directed to this small subset of female patients seeking a particular form of healthcare disfavored by the State.[32] In short, the State Defendants have failed to demonstrate that "maternal health and safety" is a compelling governmental interest that motivated, in fact, the Reason Mandate and, more broadly, any of the Subject Laws. It fails a strict-scrutiny review in this case.

iii. ***In this case, ensuring the integrity of the medical profession is not a compelling interest that is, in fact, furthered by the Subject Laws.***

Likewise, "ensuring the integrity/permissible regulation of the medical profession" is also unsupported and inadequate as a compelling interest *in this case*. Again, the Court could undoubtedly envision real problems or circumstances that might arguably justify, as "compelling," some statutory and/or regulatory scheme for the medical professional community at large, but this matter, on this record, is not such a case.

Indeed, as our state Supreme Court has aptly observed, there are any number of decisions, both in Kansas and elsewhere, **assuming** such an interest ***can be*** legitimate,

[32] While the "fit" to a purported "interest" is further addressed in the context of "narrow tailoring" (see infra, section IV.B.5.b), the Court notes the limitations herein to highlight the disconnect between the State Defendants' asserted "interest" in overarching maternal health/safety and any actual problem. If an actual problem existed (and had been demonstrated through admissible evidence) with respect to *maternal health/safety* that could be remedied by the Reason Mandate's various provisions, one would presume that the legislature would have drafted it, with the assistance and input of qualified public health professionals at KDHE, to gather data regarding pregnant women's circumstances and responses from *all pregnant patients*—not just those seeking to terminate their pregnancies—if it were truly seeking scientifically valid data to assist pregnant women in Kansas and improve "maternal health and safety".

important, and/or compelling, and many courts simply presume (without actually concluding) that they rise to such levels. See *Hodes I*, supra at 501; *Hodes III*, supra at 1015-16. Theoretical justifications, however, do not satisfy the clearly articulated burden the State bears: to demonstrate why the purported interest is "compelling" with ***actual evidence*** of a contemporaneous motivation underlying a statutory enactment—not merely broad-brush conclusory characterizations. *Id. at 1017* (State bears the burden to establish, with admissible evidence, the "compelling" nature of a governmental interest, rather than articulating merely "theoretical" or "abstract" interests.).

No credible and relevant evidence in the record reflects an urgent problem with the regulation/licensure of the medical profession, either generally or specifically as to the small number of providers offering abortion services, that motivated our legislature to enact the WRTKA or the Reason Mandate.[33] There is no credible evidence[34] that the Provider plaintiffs (or the obstetrical community more broadly) have been engaged, at

[33] In fact, the Court questions whether the government's interest in "upholding the integrity of the medical profession," *with respect to the WRTKA and the APR Mandate*, are even legitimate in this case—much less compelling—given the trial record. Again, that interest could be considered generically and academically legitimate, but the proof must be in the proverbial pudding. And the State Defendants have provided none. There was no credible evidence of an identified urgent problem (whether existing or imminent) and no credible evidence supporting the laws being motivated by such a problem. The State Defendants arguments amount to nothing more than empty aspirational goals untethered to actual temporally-related evidence.

[34] As the Court has noted in its factual findings, the Court finds the State Defendants' witnesses who testified to their abortion experiences long before the WRTKA was enacted and/or amended (years or decades prior) to be simply not credible and not material to the issues presented. Such temporally-distant personal experiences, disconnected from the legislative process, cannot be deemed evidence of the type of "rare" or "urgent" compelling interest, years later, to survive strict scrutiny, even if they were credible. This Court did not find those witnesses, who clearly had ulterior motivations for testifying, at all credible, given their demeanor and substantive trial testimony but also given that they also appear, from review of the prior deposition transcripts as part of the limine motions to preclude, to have been identified and contacted from some form of list/database maintained by anti-abortion advocacy groups and provided to outside counsel for the State Defendants.

any material time, in an informed-consent process that categorically or even proportionally (in either a relative or quantitative analysis) fell short of generally-accepted professional standards of care. FOF ¶¶ 55, 116-125, 143, 156-157, 293-95. In that regard, there was simply insufficient evidence to demonstrate that the WRTKA or the APR Mandate were required to address a "rare" pressing problem in Kansas regarding informed consent by ***any*** group of patients, much less by abortion patients—the specific focus of the Subject Laws. *FOF ¶¶ 293-95*. Nor was there evidence that the Board of Healing Arts or the legislature observed or reported some "urgent" need to address the integrity of the profession through the WRTKA because of a significant, existing, and rare problem within the practice of the healing arts, including those providing abortion services. FOF ¶¶ 55, 143, 156-59, 293-95. This absence of evidence stands in stark contrast to the actual evidence admitted at trial by plaintiffs and to the well-recognized and understood common law legal and professional requirements for "informed consent," which reflect a robust legal, professional, and administrative oversight process for medical professionals in Kansas. FOF ¶¶ 5-7, 55, 66, 71, 73, 116-25, 143, 147-49; see also J. Entry on Temp. Injunction, Index No.85, pg.14-16, 44-46, 79 n.50. It is uncontested that that robust process existed at all times material to the enactment of the Subject Laws. There simply is no evidence in this record to suggest any deficiency or shortcoming implicating informed consent. FOF ¶¶ 293-95.

The Court highlighted such deficiencies with respect to the WRTKA in its Temporary Injunction Order [Index No. 85], and the State's failure remains equally glaring following trial. Given the complete absence of any credible evidence of an actual problem, "ensuring the 'integrity' of the medical profession" does not constitute a

"compelling" governmental interest, as it relates to the Subject Laws,[35] and particularly as it relates to the WRTKA, including the APR Mandate.

iv. In this case, protecting and/or respecting potential life/the fetus is not a compelling interest.

Lastly, the Court must also reject arguments that protecting and/or respecting potential life[36] qualifies as a "compelling" state interest ***in this case***, given the record presented at trial. Certainly, protection of and/or respect for potential life is a legitimate and perhaps (in an appropriate case) an important interest, as a general statement and as courts have previously noted. The Court also suspects that such an academic interest ultimately could develop (along with a fetus) to the point that it qualifies as

[35] The State Defendants' scattershot approach to its purported "interests" largely does not identify which "interest(s)" is purportedly served by (and reflect the motivations for) any of the specific laws at issue (see Pretrial Order, Index No. 630). So, it is difficult for the Court to evaluate which items to specifically address without embarking down multiple academic "rabbit holes." But it appears obvious to the Court that "regulation" or "ensuring the integrity" of the medical profession is not really applicable to the Reason Mandate, which, by its plain terms (and according to the State Defendants), is merely an involuntary purported "data collection measure" to gather information from only those pregnant women in Kansas that seek to terminate their pregnancy. Nothing in the evidence presented, the plain language of the Reason Mandate, or its legislative history supports medical professional regulation as an "interest" sought to be served by this data collection from patients. To the extent that the State Defendants imply or assert otherwise, such arguments are rejected.

[36] The Court will include what appears to be a sub-interest of "reduction of fetal pain" in this asserted interest by the State Defendant. However, this concern simply cannot constitute a compelling governmental interest under Kansas law and in this case, given the statutory timeframe during which abortion is permitted and given the overwhelming medical consensus on the concept of "fetal pain," as persuasively presented at trial. In a courtroom, facts matter; science matters. And there can be no reasonable argument on this record as to whether "fetal pain" exists and can be "experienced" in utero prior to 22 LMP, the normal statutory cutoff for abortion in Kansas. Prior to 22 weeks LMP, a fetus lacks the necessary physiology to "experience" pain, as that concept has been defined within the scientific/medical community addressing pain. In fact, the timeframe in which a fetal pain "experience" is biologically plausible/possible is almost certainly much later in a pregnancy—if at all. Thus, the Subject Laws lack any nexus to this proffered interest. To the extent that the State Defendants offered witnesses' opinion testimony on this point, the Court found that testimony on fetal pain wholly unbelievable, biased, and completely at odds with fetal development, as currently understood by mainstream medicine and presented at trial. The State Defendants' efforts to conflate "nocioception" with conscious pain experience in a fetus, as well as their experts' efforts to equate a fetus *in utero* to a neonate, were neither credible nor persuasive. Consequently, the sub-interest of "reducing fetal pain," if it is even an interest, does not and cannot constitute even a legitimate state interest during the relevant times—much less a compelling one that is, in fact, furthered by any of the Subject Laws.

"compelling," *at some hypothetical point* after both 22 weeks LMP and viability, as determined by the patient's provider—in his or her professional judgment according to accepted obstetrical standards of care. See KSA 65-6701(m)(2026) (defining "viable"). In the Court's view and analysis, this interest really turns upon and becomes a function of when along the pregnancy spectrum it is judged.

Particularly with respect to a woman's natural and fundamental right to bodily autonomy (including the right to proceed with or terminate a pregnancy), placing an asserted State interest along the spectrum of constitutional legitimacy and/or importance (i.e. illegitimate, legitimate but unimportant, important, or compelling) generally involves consideration of both the nature and timing of the State's action/regulatory effort, in the context of the facts and surrounding circumstances. See e.g. *Roe v Wade*, 410 U.S. 113, 159-163, 93 S.Ct. 705, 35 L.Ed. 2d 147 (1973) (noting that at some point in time, a woman's privacy right is no longer sole and that the right must be balanced in light of circumstances at that juncture); *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 448, 103 S. Ct. 2481, 2502, 76 L. Ed. 2d 687 (1983) (evaluating state's claimed interests in light of relevant stage/progress of pregnancy) (overruled by *Planned Parenthood of SE Penn. v. Casey*, 505 U.S.833, 112 S.Ct. 2791, 120 L.Ed. 2d 674 (1992)); *A.C.L.U. of Kansas & W. Missouri v. Praeger*, 863 F. Supp. 2d 1125, 1131 (D. Kan. 2012) (framing analysis using stage of pregnancy to assess constitutional permissibility of state statutes governing abortion). Thus, a particular asserted interest in potential life can be, academically, legitimate or even important at some point in time, and it could be more or less important (and even rising

to the level of a rare "compelling" interest) at some other point along the relevant timeline. See *Roe*, supra.

The relevant timing in Kansas of a woman's right to exercise her bodily autonomy illustrates why the State Defendants' claimed "interest" in protection of and respect for potential life/the fetus is not a compelling governmental interest in this case and relative to the Subject Laws.

A review of Kansas law is instructive. Kansas maintains statutory cutoffs and criteria for abortion. Termination of a pregnancy is permitted prior to viability and so long as it occurs prior to 22 weeks LMP, except in rare exceptional/emergent circumstances. See K.S.A. 65-6703 (2025). And, in light of *Hodes I* and its progeny, that right of a pregnant woman to autonomously decide whether to proceed or not with a pregnancy is fundamental. See *Hodes I*, supra at 660. Thus, in Kansas, prior to the viability threshold along the pregnancy continuum (presumptively 22 weeks LMP in Kansas), a woman's fundamental right eclipses any such proffered State interest in protecting/respecting a fetus. Otherwise, a woman's fundamental and inalienable natural right would be something less than "fundamental" or "inalienable." The corollary is that protection of a fetus/potential life simply cannot be a "compelling" State interest at this stage of pregnancy. As such, Kansas law dictates that the State Defendants' arguments factually, logically, and legally fall short—protection of/respect for potential is not a compelling interest under these facts.

And the State Defendants brought forth no affirmative evidence to persuade this Court as to why the "protection of *potential* life" should somehow supersede and supplant a pregnant woman's own fundamental rights at such early stages of

pregnancy—when both the law and the overwhelming evidence reflects that the *potential* life was not yet viable. Indeed, while counsel and some of the State's witnesses offered impassioned arguments for the protection and preservation of potential life at any stage of pregnancy, those arguments largely reflect broad aspirational goals and philosophical/moral/spiritual perspectives which are not persuasive evidence of a "compelling" interest. Consequently, the Court concludes that the State has not demonstrated that protection of "potential life" during the pre-viability stage in Kansas-- when abortion is legal--rises to the level of a "compelling" interest, in the context of the Subject Laws' mandates.

b. The Subject Laws are not narrowly tailored to effectuate any compelling governmental interest and are both overbroad and underinclusive.

Even if the State Defendants had affirmatively demonstrated that there was some compelling governmental interest underlying each of the Subject Laws,[37] or if the Court were simply to presume that the last three discussed were "compelling," the simple fact is that the Subject Laws are not narrowly-tailored to effectuate those articulated interests, and they certainly do not employ the least-restrictive means**.** Nor have the State Defendants demonstrated that the Subject Laws, ***in fact***, further or effectuate the asserted interests in the slightest. And the evidence presented at trial reflects that the Subject Laws would run, in many respects, contrary to the government's stated

[37] Interestingly, the State Defendants, during closing arguments, primarily referenced only a *post-hoc* interest in "enhancing patient autonomy." While counsel also made passing reference to maternal health and adequate "informed consent," the other purported justifications were noticeably absent. The Court finds this illustrative, as a commentary by the State Defendants on the evidence actually adduced at trial. Since the State Defendants have so prominently placed this "autonomy interest" in their case at trial, the Court will address the "autonomy" argument, despite its clear and constitutionally-inadequate *post-hoc* nature, on this record.

"interests," which is an additional reason why the Subject Laws cannot survive strict scrutiny.

In a strict scrutiny analysis, the concept of "narrow tailoring" is often described in terms of three components, in order to comport with "precision of regulation." *Hodes II*, supra at 954. First, is the legislative scheme the "least restrictive means"? *Id.;* see also *Boos v. Barry,* 485 U.S. 312, 329, 108 S. Ct. 1157, 99 L. Ed. 2d 333 (1988) (even if action serves government interest, it is not narrowly tailored if "a less restrictive alternative is readily available"); *United States v. Brandon,* 158 F.3d 947, 960 (6th Cir. 1998) (narrow tailoring requires government action be "least restrictive ... means of satisfying" compelling interest)

Second, it must not be underinclusive, meaning "it fails to regulate activities that pose substantially the same threats to the government's purportedly compelling interest as the conduct that the government prohibits." *Hodes II*, supra at 954-55; see also *NIFLA*, supra at 2375-76 ("underinclusiveness raises serious doubts about whether the government is in fact pursuing the interest it invokes, rather than disfavoring a particular speaker or viewpoint.") (citation omitted). Underinclusive regulations do not withstand strict scrutiny because they " 'diminish the credibility of the government's rationale' for infringing on constitutional rights and generate suspicion that the selective targeting betrays an impermissible motive." *Id.* See also *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 547, 113 S. Ct. 2217, 124 L. Ed. 2d 472 (1993) (" 'a law cannot be regarded as protecting an interest "of the highest order" ... when it leaves appreciable damage to that supposedly vital interest unprohibited' "); *Williams-Yulee v. Florida Bar*, 575 U.S. 433, 448-49, 135 S. Ct. 1656, 191 L. Ed. 2d 570 (2015)

(explaining “underinclusiveness can raise ‘doubts about whether the government is in fact pursuing the interest it invokes, rather than disfavoring a particular speaker or viewpoint’ ” and “reveal that a law does not actually advance a compelling interest”); *Bishop v. Smith*, 760 F.3d 1070, 1081-82 (10th Cir. 2014) (ban on same-sex marriage not narrowly tailored because it is underinclusive; government contends ban serves interest in children being raised by biological parents but fails to address other contexts in which children will be raised by non-biological parents).

And lastly, a regulatory scheme, to be narrowly tailored, must not be overinclusive, meaning it regulates activity that does not affect the government's asserted interest. *Hodes II*, supra at 955; see also Volokh, *Freedom of Speech, Permissible Tailoring and Transcending Strict Scrutiny*, 144 U. Pa. L. Rev. 2417, 2422 (1996); see also *Citizens United v. Fed. Election Commission*., 558 U.S. 310, 362, 130 S. Ct. 876, 175 L. Ed. 2d 753 (2010) (statute prohibiting corporations from funding speech supporting political candidates was overinclusive in relation to interest in preventing dissenting shareholders from being compelled to fund corporate speech because it applied to all corporations, including those with a single shareholder); *Bishop*, 760 F.3d at 1082 (ban on same-sex marriage not narrowly tailored because it is overinclusive; ban goes well beyond serving interest in ensuring children raised by biological parent—it denies same-sex couples fundamental right to marry); *State v. Burnett*, 93 Ohio St. 3d 419, 429, 755 N.E.2d 857 (2001) (“ ‘A statute is narrowly tailored if it targets and eliminates no more than the exact source of the “evil” it seeks to remedy.’ ” [quoting *Frisby v. Schultz*, 487 U.S. 474, 485, 108 S. Ct. 2495, 101 L. Ed. 2d 420 (1988)]).

Given the state of the evidence and arguments raised, the Court will address the Subject Laws' tailoring only with respect to the primary justifications/governmental interests asserted by the State Defendants, which were addressed primarily in closing arguments.[38] The Court concludes that it is unnecessary to address the tailoring for all other rationalizations presented by the State Defendants, given facially fatal flaws and the *post hoc* nature of those interests.

i. "Enhancing autonomy"

WRTKA:

Even if "enhancing autonomy" were a "compelling" interest and something other than a *post-hoc* improper justification, the WRTKA is not narrowly tailored to accomplish this "interest." First and foremost, if the State truly wanted to ensure enhanced decision-making "autonomy" by pregnant patients over their own bodies, the most narrowly tailored way to promote this self-determination, on this record, is, in the Court's view, by staying out of the patient's exam room and treatment decision-making process entirely. It is certainly not a narrowly tailored remedy to an existing problem for the Act to delay and/or deny care in order to inundate pregnant patients considering abortion with often superfluous information that is inaccurate, misleading, and potentially harmful to those women. Despite the State Defendants' apparent contention that 'more is

[38] The State Defendants did present some evidence at trial regarding "respect for potential life," even though they appear to have ignored or essentially abandoned these arguments in closing argument, instead only obliquely referencing "fetal life" in the context of an "autonomous" decision by pregnant women. See Trial Tr., vol. VII (PM), 67-110. To the extent that they have raised and adequately preserved this point with an isolated and brief reference, the Court rejects the same and finds the Subject Laws are not narrowly tailored to accomplish this stated purpose (respect for fetal life) and are overinclusive for the very same reasons as the Subject Laws are with respect to the purported interest of "enhancing autonomy."

better,' when it comes to making this undoubtedly significant and serious decision, sometimes (and in light of the record in this case) more is just . . . . more.

The overwhelming evidence at trial demonstrates why the WRTKA is simply not "narrow" in its tailoring. First, abortion patients presenting to obstetrical providers, such as Comprehensive Health, have already thought about and considered their decisions before presenting to the clinic and have generally decided that they wish to proceed because it is care that they desire and need. FOF ¶73; see also Aff. Of Nauser, Index No. 3, pg. 6; Aff. Of Alsadan, Index No. 3, pg. 23. And there was an absence of credible evidence of any urgent or rare problem in the context of informed consent, with Provider plaintiffs, with obstetrician/gynecologists that perform abortion, or with medical professionals generally, that necessitated state action to fix. FOF, ¶¶ 293-95. It also was not seriously contested that much of the information provided by the WRTKA likely wasn't material or desired by many patients. FOF ¶¶ 194, 197, 218, 220-21, 228. Yet, there was heaps of credible evidence that significant portions of the required information was scientifically inaccurate, misleading, and potentially traumatizing/harmful. FOF ¶¶ 194-215. And the evidence demonstrated persuasively that information "overload" in fact undermines the decision-making process and the right to make knowing autonomous decisions when deciding whether to terminate or maintain a pregnancy. FOF ¶¶ 220-22. This inundation by the WRTKA rests against the backdrop of mandatory waiting periods, regardless of any patient-specific knowledge or decisional certainty. FOF ¶¶ 13, 219, 223, 228. The WRTKA leaves no opt-out or professional judgment/discretion by the provider to omit any of the information or discussions, regardless of circumstances or what is medically material. In that regard, it deviates

vastly from the existing standard of care for obstetrical physicians, like the requirements for all health-care providers. FOF ¶¶ 29, 120-125, 216. It is simply not a narrowly-tailored process that utilizes the least restrictive method to further any interest in "enhanced" patient autonomy.

Indeed, the Court can envision any number of other methods to "enhance [pregnant women's] bodily autonomy" that are less intrusive and restrictive on the women's underlying fundamental rights. For just one example, the State Defendants could have simply enacted laws creating a public awareness campaign in Kansas regarding some or all of the WRTKA's mandated disclosures and encouraging or facilitating the marketing of similar materials online or *through willing providers* to benefit **all** pregnant women, if they truly believed that such information would, in fact, enhance autonomy in their decision making—whatever the result.

A statutory scheme, which mandates the timing, form, nature, and extent of information, in excruciating detail, for ***all pregnant patients seeking an abortion*** (but not for all pregnant patients) is simply not "narrowly tailored" or crafted using the "least restrictive means" to promote enhanced patient autonomy. Simply put, the State Defendants did not adequately support its position that the WRTKA is narrowly tailored to effectuate the interest of "enhancing women's autonomy" or that it, in fact, does effectuate that purpose.

Further, the WRTKA is both over-inclusive and under-inclusive in its reach, which confirms its lack of "narrow tailoring." The WRTKA is a textbook example of an over-inclusive scheme. Regardless of a pregnant woman's prior or existing knowledge base, her level of decisional certainty, her desire to proceed, and the appropriate informed

consent discussions[39] with her own trusted health care professional(s), the WRTKA compels her to receive and consider volumes of additional non-standard-of-care-based information, which she may or may not need or want. She then must wait out a state-mandated arbitrary "clock" before exercising her "autonomy" and receiving this specific form of healthcare. The record reflects that most women do not need or want such a process or the totality of the information required by the Act to ensure their decisions regarding maintaining or terminating their pregnancy are "autonomous." FOF ¶¶ 13, 154-56, 176, 191, 216-218, 285-95. Furthermore, the WRTKA prevents women who need and want the care offered by plaintiffs from obtaining it based on equally arbitrary paperwork technicalities. FOF ¶¶ 174-93. Thus, the WRTKA is overinclusive because it regulates activity far beyond the problem that it purportedly seeks to remedy (women who want or need this additional information to make their own decision on pregnancy status or that need some additional period of time to consider their decision). See *Hodes III*, supra at 955-56 (noting "narrowly tailored" requires that the statute target and eliminate "no more than the exact source of the 'evil' it seeks to remedy.") (citations omitted).

Simultaneously, the WRTKA is also underinclusive, and as a result, reveals an impermissible motive of favoring its preferred viewpoint (childbirth) and disfavoring of the opposing viewpoint (abortion).

If the State Defendants' espoused theory is that all of the information and delays are necessary for truly "voluntary and informed consent," as a component and

[39] As already required by and pursuant to both existing professional standards of care within the subspecialty and Kansas law.

"enhancement" of bodily autonomy, then it fails to regulate similar scenarios that pose equivalent "threats" to the purported "interest" asserted. All parties appear to agree that the decision of whether to proceed with a pregnancy through delivery or to terminate that pregnancy is a complicated, life altering, and deeply personal decision. Yet, the information required by the WRTKA regarding, for example, their provider's qualifications and state of residency, the progress of their pregnancy at various developmental stages, the purported risks (even if inaccurate) of an abortion, information on adoption, child support, legal basics on parentage, and alternatives (including termination of that pregnancy) presumably would be informative and appropriate for **every pregnant woman** to consider, so that they each can purportedly enhance their own "autonomy" in the decision on how to proceed.

The WRKTA, however, does not cast so wide a net. Instead, it targets **only** pregnant women seeking ***to terminate*** their pregnancy--and not all pregnant women—even though both sets of patients are confronted with an equal, important, and inevitably life-changing decision. In doing so, the WRTKA does not constitutionally advance the purported state interest in autonomy and, instead, attempts to transform the idea of an "autonomous" decision into one of the government's preferred outcome. It is blatantly underinclusive and smacks of an improper, pretextual, and constitutionally-infirm motive.

APR Mandate:

As the saying goes, the apple never falls far, and the APR mandate fails as equally as the original Act it supplements. It is not narrowly tailored to effectuate a governmental interest in enhancing autonomy, and it is not the least restrictive method

for accomplishing the stated goal. Further, the evidence demonstrates that this statutory amendment actually undermines, rather than "enhances," the autonomy of pregnant women by providing them with statements grounded in junk science that are misleadingly presented as established and safe medical practice grounded in reliable data and scientific principles.

The Court presumes, as with the WRTKA generally, that the State's position is that "knowledge is power," so to speak, and, thus, the APR Mandate "enhances autonomy." However, as the evidence revealed at trial, not all information is good information that assists an individual in independent decision making (FOF ¶¶ 215-22, 227), and there are certainly less-restrictive methods for the State to communicate the substance required by the APR Mandate.

Again, the State Defendants could instead seek to impart this information and data through highway billboards, other public education campaigns, social media campaigns, broadcast or other media efforts, or on its own public agency websites. Doing so would allow those interested individuals to access the substance of the APR Mandate, which is not considered standard of care and is well outside mainstream medical consensus (FOF ¶¶ 76, 102, 106, 111, 194-215), without compulsion. That would, likewise, not conscript providers into acting as the State's figurative megaphone, requiring them to speak the State's message and inform patients of this theory—regardless of their thoughts on the issue. Such alternatives to the APR Mandate would be far less restrictive methods than that proffered through the statute's requirements and would be more narrowly tailored to provide those interested women with the data

the State seeks to embrace. Thus, the APR Mandate simply is not narrowly tailored to effectuate the asserted interest in "enhancing autonomy."

Further, any suggestion that the APR Mandate promotes or, in fact, "enhances" bodily autonomy is, at best, perplexing. As discussed herein and in the Court's prior opinions precluding certain testimony by some of the State Defendants' witnesses,[40] APR theory is just that: an untested and experimental idea with no legitimate grounding in existing, validated, peer-reviewed scientific processes or mainstream medical practice. See FOF ¶¶ 205-215; see also Index No. 622, J. Entry on the Parties' Various Motions to Exclude or Limit Expert Witnesses, pp. 7-16. It is, at best, anecdotal and unproven, given this record and the existing state of medical science. Such legislatively mandated information finds no foothold in generally-accepted medical practice or within the applicable standard of care, as detailed by all of the major obstetrical/gynecological professional organizations and by other witnesses at trial (FOF ¶¶ 205-215). And it constitutes yet another piece of the scores of information incorporated into the WRTKA that would inundate pregnant women contemplating the termination of their pregnancy.

APR's experimental ideas implicitly undermine the gravity and permanency of the decision that such women face—thereby sabotaging, rather than enhancing "autonomy" and voluntary informed decision making (*Id.*). It would, for all practical purposes, render what is a solemn, intimate, binary, and presumably final medical/healthcare decision as to a pregnancy appear less so. In that respect, the APR Mandate appears unlikely to actually advance and promote a pregnant woman's autonomy at all. It confuses and

[40] Entered in response to plaintiffs' motions brought in accordance with K.S.A. 60-456.

undermines it with speculative fringe theories—not scientifically established medically-material data.

And if the goal is "enhancing autonomy," much like the rest of the WRTKA, the APR Mandate is also overinclusive. Regardless of patient experience, knowledge, decisional certainty, or desire, the APR Mandate forces patients to wait a mandatory 24-hours[41] after being informed by their health care provider about this experimental theory. With respect to this extremely important and binary decision, the APR Mandate requires that the pregnant woman be advised that it "may be possible to reverse" her decision to terminate her pregnancy and the abortion process initiated by taking Mifepristone. It then requires the exact same information to be provided, yet again, after the first dose of Mifepristone is administered or dispensed. The APR mandate is over-inclusive because it forces women who are already sure of their decision to wait at least a day before they can obtain the care they desire, all in the name of ensuring women are exercising "more" or "better" autonomy in making their decision through the provision of the fringe speculative theory espoused by the State. Its requirements, accordingly, regulate activity well beyond the asserted target and motivation for the scheme: that pregnant patients need or want this additional "reversal" information (on a dubious and experimental theory) to "enhance" their autonomous decisions about their pregnancy.

It is also underinclusive as a governmental interest, insofar as it attempts to address the "enhancement of autonomy" of pregnant women. In demanding that some

[41] As part of multiple delays and "time outs" prescribed by the WRTKA for the patient.

pregnant women receive additional information (of dubious validity and in the name of "enhanced" autonomy) that their choice to terminate their pregnancy need not be a "final" decision, the State makes no corresponding effort to ensure that other pregnant women (presumably presenting for ongoing prenatal care prior to childbirth) are also advised that they can, likewise and in the interest of "autonomy," choose to change their minds and end their pregnancies within certain timeframes and through the normal statutory cutoffs in Kansas. The one-sided nature of the APR Mandate's disclosure and procedures raises serious doubts about the State's true motivation. See *Hodes III*, supra at 962 ("Under inclusivity *reveals* something constitutionally offensive."). It appears more likely aimed at targeting pregnant women that wish not to have a child, in an effort to change women's decisions to conform with the State's goals—not to promote self-directed voluntary decisions on such a solemn and final choice. Thus, the Court rejects the State Defendants' position that the WRTKA and the APR Mandate are narrowly tailored to advance any compelling governmental interest in this case or that they advance such an interest, in fact.

Reason Mandate:

The State Defendants largely fail to address how, if at all, the Reason Mandate furthers this asserted *post-hoc* interest of "enhancing autonomy." Instead, in closing arguments, counsel merely suggested that it is a set of "voluntary" questions that the state is asking, and counsel implied that it really doesn't "undermine" the concept of a woman's fundamental right to bodily autonomy. Trial Tr. vol. VII (PM), 105:4-17 (Nussbaum). But, as the Court has already concluded, it does. See discussion, supra Sec. B.4.

And since the State Defendants have not articulated or clearly proffered evidence as to how the Reason Mandate furthers, in fact, this purported purpose (enhancing pregnant women's bodily autonomy) in a narrowly-tailored way, the Court will not further address the point, other than to observe that the State Defendants have wholly failed to meet their burden of proof on this issue.

ii. "Maternal Health/Safety"

The Subject Laws are, similarly, not narrowly tailored to effectuate the State Defendants' additional asserted purpose of promoting "maternal health/safety" either. Nor have they demonstrated that the Subject Laws do, in fact, advance such interests, even if they were demonstrated to be compelling in this case. Thus, the State Defendants again fail to satisfy their legal burden of proof.

WRTKA:

The State Defendants have again failed to demonstrate that the WRTKA is narrowly tailored to effectuate the government's interest "promoting maternal health/safety" (even if one were to assume it was compelling in this case) in the least restrictive manner.

At this juncture, it must be apparent that the WRTKA covers a broad array of mandated information. And a pregnant woman that is considering the termination of her pregnancy must receive and consider that voluminous data before beginning statutory waiting periods imposed prior to receiving her desired care. Those disclosures range from whether their provider has malpractice insurance, to inaccurate statements on the risk of breast cancer and premature birth following abortion, to descriptions of fetal

development (some accurate and others not), to legal basics on parentage and child support. The nexus to "maternal health and safety" of many of the Act's requirements is unexplained by the State Defendants with any credible evidence. And it is, frankly, largely inexplicable, particularly given the mandatory waiting periods and non-discretionary nature of the disclosures. The increasingly broad array of the disclosure requirements[42] expressly demonstrates, why it is not a narrowly-tailored approach to further, in fact, "maternal health and safety," as a purported governmental interest. It certainly has not been proven by the State Defendants that the Act is the "least restrictive means" to accomplish the asserted goal.

And, in fact, the evidence at trial demonstrates how the WRTKA actually, in all likelihood, threatens maternal health and safety, rather than improving it. There is no question that the risks to a pregnant woman increase over time throughout a pregnancy. Each day of pregnancy results in greater risk of both morbidity and mortality to the pregnant woman. FOF ¶¶ 127, 139, 142, 296; Ex. 68, pg. 10. Yet, the Act requires mandatory 24-hour waiting periods, which in many instances result in prolonged and needless delays and, in some cases, outright denials of care. FOF ¶¶ 175-77;179, 185, 189-192, 216-228. As a result, those women are necessarily subjected to increased risks to their own health and safety, merely as a function of continued pregnancy and a statutory inability to freely express her choice.

Not only do the delays themselves threaten maternal health and safety, but the mandated information required to be disclosed does as well. Much of the information

[42] As developed in the Court's factual findings, the WRTKA has evolved over time to become significantly more ideologic, more burdensome, and simply not objective.

contained in the disclosures appears scientifically and medically inaccurate or misleading, which creates a significant risk of ill-informed or misinformed decision-making by pregnant women, who may rely upon the flawed information that the State demands under the Act. FOF ¶¶ 83, 194-215, 217-22, This seems to the Court likely to increase the risks to pregnant women.[43] Thus, if the government's actual goal was to further maternal health, the evidence demonstrates that the Act, in fact, fails in furthering that goal. It certainly does not support a conclusion that the goals are furthered in the least restrictive way and in a narrowly tailored fashion.

The WRTKA is also both overinclusive and underinclusive, with respect to "maternal health/safety," for many of the same reasons that it is with respect to the purported interest of "enhancing autonomy." Rather than restate that analysis, the Court refers to its discussion above, see Section IV.B.5.b.*i*, supra. It targets all pregnant women contemplating abortion, whether they want or need the data, but fails to provide equivalent information to all other pregnant women. Simply stated, the WRTKA is not narrowly tailored, using the least restrictive means, to accomplish the purported interests of "maternal health and safety," even if the State Defendants had demonstrated it to be a compelling governmental interest in this case. Nor does the

[43] For example, the evidence presented on APR theory (limited studies and literature) affirmatively reflects a potentially-significant risk of hemorrhage in pregnant women that do not proceed with the second medication (Misoprostol) in a medication abortion. But that is the very process contemplated and required under APR theory. While the evidence has been provided in a very limited and incomplete study, which was stopped due to such safety concerns, it constitutes strong evidence to this Court that the amended WRTKA actually undermines or decreases "maternal health/safety" with the inclusion of the APR Mandate, given the recognized risk of hemorrhage from using the described APR protocol. FOF ¶¶ 207-13, 215. Further, continuing to be pregnant increases the relative risk to a woman, as the health risks increase throughout the pregnancy. FOF ¶ 296.

evidence demonstrate that it, in fact, furthers this interest, and thus, the State Defendants fall short of their affirmative burdens in this case.

APR Mandate:

As part of the amended WRTKA, the APR Mandate also fails requisite constitutional scrutiny because the State Defendants have, likewise, failed to demonstrate that this amendment/provision is a legislative effort that, in fact, advances the State's purported interest in maternal health and safety, in fact, in a narrowly-tailored fashion. Even if this Court were to ignore the evidence and its own finding that "maternal health/safety" is not a compelling interest in this case, the statutes comprising the APR Mandate would still fail constitutional scrutiny because they do not, in fact, advance this interest in any narrowly-tailored fashion and do not reflect the least restrictive means.

On its face, the APR Mandate appears to have nothing to do with promoting or furthering "maternal health/safety." And there is simply nothing in the record, the plain language of the APR Mandate, or the legislative discussions or history, that credibly advances this "interest" as being a purpose that the statute furthers, in fact. Thus, the State Defendants fall short on this issue as well and fail to meet their burden of proof.

The APR Mandate is also not "narrowly tailored" under any reasonable definition of that concept, for the very same reasons that the WRTKA, as a whole, is not narrowly tailored. It conditions desired medical care upon the receipt of mandatory disclosures (in multiple formats and at multiple times), followed by waiting periods and delays for repetition. The State Defendants have not even colorably argued, much less

demonstrated with affirmative evidence, that the APR Mandate actually advances the interests of "maternal health/safety" in the least restrictive manner.

In truth, the APR Mandate runs counter to this very interest. This unverified and experimental theory ultimately requires a pregnant woman who begins a two-medication abortion (mifepristone followed by misoprostol), to refrain from taking the second medication and, instead, to undergo the administration of a substantial dose of progesterone. See FOF ¶ 207. However, APR treatment falls well outside the standard of care within the medical/obstetrical community, and it is quite simply unproven junk science that threatens the health of pregnant women (risk of hemorrhage attendant to theory and by not completing the established, safe, effective two-medication protocol), without identifying those risks from this unproven theory. FOF, ¶ 215. As such, the APR Mandate directly undermines any interest in maternal health and safety, even if it was compelling here.

The very limited and vastly incomplete scientific studies on this subject fall far short of demonstrating APR protocol efficacy. If anything, the studies explain the actual dangers to maternal health brought on by following through with this fringe theory. The *Creinin* study, which was highlighted by both sides in this case, strongly suggests to this Court the existence of potential risks to maternal health and safety attendant to the failure to complete the well-established, safe, and effective two-medication protocol for a medication abortion. See FOF ¶¶ 110-111, 207-215; Pls.' Ex. 82; see also Pls.' Ex. 84. In the *Creinin* study, researchers sought to test APR theory. Of the 40 women they sought to enroll, researchers only actually enrolled twelve participants. Pls.' Ex. 84. And of those twelve, three that participated in the study (25% of study participants) were

emergently transported because of uterine hemorrhage when they took only mifepristone, followed by a dose of progesterone or of a placebo. *Id*. Contrary to conventional medical practice and the applicable standard of care, these study subjects were not administered the second medication, misoprostol, which would have completed the medication abortion. *Id.* The study was subsequently abandoned due to maternal safety concerns. *Id.*

Even though a small and incomplete study, the mere fact that the *Creinin* study authors, in conjunction with their Institutional Review Board, abandoned the project due to these major health concerns stemming from not completing the standard, demonstrably safe, and well-established medication abortion process is telling and reflects how this fringe theory of APR actually presents *increased risk* to pregnant women than a standard medication abortion. Indeed, the authors expressly warn that:

> "patients in early pregnancy who use only mifepristone may be at high risk of significant hemorrhage" and [we] caution legislators against laws "mandat[ing] counseling or provision of any treatment when we do not fully understand treatment efficacy (including best route of administration, dose, and duration) and safety."

Id. The APR Mandate certainly does not advance any interest in "maternal health/safety," either in theory or in fact. Therefore, the APR Mandate fails strict scrutiny for this additional reason.

Reason Mandate:

The Court's conclusion regarding the connection between the Reason Mandate and "maternal health and safety" echoes that reached with respect to the purported interest in "enhancing autonomy." The State Defendants broadly fail to address how, if

at all, the Reason Mandate, *in fact*, furthers, in a narrowly-tailored fashion, the asserted interest of "maternal health and safety."[44]

Indeed, much like the other statutes at issue, the Court can envision any number of ways that are more narrowly-tailored and less restrictive in their approach than the Reason Mandate's conscription of health care providers to ask, record, and report on mandated questions to their pregnant patients seeking abortion as a condition precedent to providing health care services. For instance, the State could instead authorize state-wide *voluntary* surveys created and issued by the professionals at KDHE to a broad spectrum of female patients of child-bearing age. Or it could authorize and fund legitimate *independent* research studies with established goals, guided by an Institutional Review Board and conducted according to well-established professional public health standards. Such a study could gather actual, germane, and scientifically-valid data[45] through *voluntary* participation of women (or more specifically, pregnant women) in Kansas that implicate maternal health or safety data points. These are only a few possible and more narrowly-tailored methods that might ***actually further*** a potential interest of "maternal health and safety" (if that was, in fact, a compelling interest) through usable data obtained for a specified purpose(s) under a valid peer-

[44] As with various issues presented in this case, the State Defendants have adopted a scattershot approach to their legal and factual development, which often leaves this Court in a position that it is left to "connect" whatever dots they have periodically laid through undeveloped and unsupported legal "buzzwords." It is not the Court's role or responsibility to develop and interpret these issues for the State. It is their obligation to demonstrate them to the Court and satisfy their legal burden under the applicable constitutional framework. This they have not done.

[45] Indeed, the Reason Mandate also appears underinclusive, insofar as it doesn't even fully address the population of women that seek abortion in Kansas. Presumably, some Kansas women obtain medication abortion regimes through the mail from potentially out-of-state providers and are not even considered under the Act's requirements.

reviewed methodology. And such processes would do so in a far more narrow and less restrictive manner, given the voluntary nature of such activities. The Reason Mandate is not so tailored in its approach.

Ironically, in closing arguments, counsel insinuated that because State is "not bound by any constitutional requirement to have an IRB board," it has free reign to "ask[] question[s] of women." Trial Tr. vol. VII (PM), 105:8-10 (Nussbaum). Such a proposition blatantly ignores constitutional law and the burden the State faces to justify its actions. The same shortcoming exists with respect to the State's suggestion that the "voluntariness"[46] of some (but, crucially, not all) questions means that a fundamental right to bodily autonomy is not undermined or impaired. Trial Tr. vol. VII (PM), 105:4-17 (Nussbaum). Counsel articulated nothing (nor did the State's witnesses testify regarding) about how the Reason Mandate, actually and in fact, furthers the interest of "maternal health and safety" in any concrete or identified way.[47] Nor did they proffer any evidence demonstrating that this purported interest cannot be furthered in a less-restrictive method or a more narrowly tailored fashion. And since the State Defendants have not articulated or clearly proffered credible evidence as to how it furthers, in fact,

[46] "Voluntary" only in the sense that patients under the Act may decline to answer the "most important reason" portion of the mandate. It is not voluntary in the sense that the questions, which are ideologically slanted and potentially stigmatizing, can be omitted by the provider during his/her discussions with the pregnant patient. The pregnant patient has no choice but to be confronted with the questions and topics. Further, other portions of the Act's mandates are expressly NOT optional to answer or to discuss. Thus, it is simply inaccurate to characterize the Reason Mandate as "voluntary" data collection.

[47] Dr. Wubbenhorst and Dr. Curlin did make passing reference in their opinion testimony as to what interests were purportedly served by H.B. 2749, in their views. However, their testimony on these points was, at best, cursory, non-specific, and generalized, and the Court found both witnesses' testimony to be so clearly biased and ideologically driven that their opinions simply carry no weight. Those broad-brush and conclusory opinions regarding what the Reason Mandate could "possibly" advance is not substantial evidence that the statutory scheme does, in fact, advance the asserted interest in a narrowly tailored way.

this purported purpose in a narrowly-tailored way, the Court will not further address the point, other than to again observe that the State Defendants have wholly failed to meet their burden of proof on this issue.

iii. "Upholding the integrity of the medical profession through reasonable regulation"

The State Defendants have also failed to demonstrate that the Subject Laws, in fact, further an interest in "upholding the integrity of the medical profession" in a narrowly-tailored fashion and in the least-restrictive manner. Thus, the Subject Laws fail strict scrutiny review for this additional reason.

WRTKA (including the APR Mandate):

Presumably,[48] the State Defendants contend that the Subject Laws further the interest of "upholding the integrity of the medical profession" because the WRTKA makes the failure to comply and provide the mandated disclosures a violation of the Healing Arts Act, which subjects medical professionals to discipline for "unprofessional conduct." See K.S.A. 65-6712 (2025). However, as discussed above, there was absolutely no credible evidence presented that the WRTKA was promulgated and enacted because either the plaintiffs or other medical professionals were not otherwise providing adequate informed consent in conformity with the existing applicable standard of care. FOF ¶¶ 6, 55-58, 156-158, 293-95. So, the Court has already concluded that the WRTKA fails strict scrutiny and is a solution in search of a problem. See discussion, Section IV.B.5.a.iii., supra (not a compelling governmental interest, in this case).

[48] The Court presumes because, as mentioned, the State Defendants' generalized and shotgun-like approach to these issues leaves much unexplained and/or unstated.

But, its problems run deeper. The statutes, which impose significant requirements on health care providers and substantially infringe upon pregnant women's rights, cannot be considered narrowly tailored or the least restrictive method, given this record and this purported interest. In fact, it appears that the least restrictive method of "upholding the integrity of the medical profession" on this record would be to simply stick with what was apparently working prior to the WRTKA. There already was (and is) a detailed and robust set of legal, regulatory, and administrative processes for ensuring that health care providers in Kansas are complying with established and generally-accepted standards of professional conduct within their relevant medical community. FOF ¶¶ 5-7; 62-67, 157. This includes administrative licensure proceedings to discipline professionals that violate the Healing Arts Act. *Id.* Given the lack of a documented or demonstrated problem on this point, the "least restrictive" means to further/advance this governmental interest appears to be to simply letting the process alone.

Instead, the State has adopted grossly underinclusive mechanisms to threaten providers, who otherwise offer their services according to the law, into compliance with the WRTKA by creating a particular form of "unprofessional conduct" applicable to only them—as obstetricians willing to provide abortions in Kansas. To the extent that it singles out this particular form of health care to establish a set of unique, burdensome, and one-sided disclosure requirements and labels them "informed consent," for no obvious reason in this record, the WRTKA fails to address and/or regulate many other similar actions/omissions within the healthcare profession that pose substantially similar "threats" to the State Defendants' asserted interest of "upholding the integrity" of the

medical profession.[49] Indeed, the Court was unable to find anywhere in Kansas law where the State seeks to micro-manage the issues surrounding the process of informed consent by medical professionals governed by the Healing Arts Act, as it does by the Subject Laws. See *Williams-Yulee v. Florida Bar*, 575 U.S. 433, 448-49, 135 S. Ct. 1656, 191 L. Ed. 2d 570 (2015) (explaining "underinclusiveness can raise 'doubts about whether the government is in fact pursuing the interest it invokes, rather than disfavoring a particular speaker or viewpoint' " and "reveal that a law does not actually advance a compelling interest"); see also *Hodes II*, supra at 954-55 (observing "[u]nderinclusive regulations do not withstand strict scrutiny because they 'diminish the credibility of the government's rationale' for infringing on constitutional rights and generate suspicion that the selective targeting betrays an impermissible motive.") (internal citations omitted). Such an underinclusive scheme, as reflected by the WRTKA, undoubtedly represents an impermissible effort to selectively target disfavored views and conduct, rather than legitimate efforts to broadly ensure the "integrity" of medical professionals in Kansas. The WRTKA (including the APR Mandate) is, in fact, unconstitutional for this additional reason, given requisite strict-scrutiny framework.

[49] The State Defendants attempt to draw parallels to other statutes or regulations, suggesting that the ability to ensure "informed consent" is a proper area for state regulation. However, their argument rings hollow when it comes to narrow tailoring, and their arguments bespeak too much. While they point to a number of other state regulations in Kansas directed to "informed consent" broadly, not one of their citations address an even-remotely similar substantive requirement as to content or mandated level of informational detail—instead recognizing the primary source of what constitutes "informed consent" lies with the professional's judgment and discretion, professional standards, and well-established common law principles. Thus, the references cited by the State Defendants (see *e.g.*, Pretrial Order, Index No. 630, pg. 57 and other citations in State Defendants' Opposition to Plaintiffs' MSJ, pg. 45. n. 4), which largely speak only to "informed consent" as *a general concept* to be addressed through professional judgment and conventional practice, belie their contentions and reflect the massively underinclusive nature of such an "interest" in ensuring the "integrity" of the medical profession. Surely, if that were the goal, substantive requirements for all types of care and treatment would be specifically dictated and detailed pursuant to the Subject Laws or analogous legislative or regulatory action. Instead, the Subject Laws merely target the views and viewpoints of a select few professionals serving in a disfavored area of medicine and with respect to this specific procedure.

Reason Mandate:

Again, the State Defendants entirely fail to address how, if at all, the Reason Mandate furthers an asserted interest in "upholding the integrity of the medical profession." The statute's plain language reveals no obvious or patent nexus to such an interest. And since the State Defendants have not articulated or clearly proffered evidence as to how it furthers, in fact, upholding the integrity of the medical profession in a narrowly-tailored way, the Court will not belabor the point, other than to observe that the State Defendants have wholly failed to meet their burden of proof on this issue.

In sum, the Subject Laws infringe upon and violate pregnant women's fundamental rights to bodily autonomy, as guaranteed by Section 1 of the Kansas Constitution's Bill of Rights. They lack any compelling governmental justification and are not narrowly tailored to effectuate the State's proffered interests in the least-restrictive manner. And they do not, in fact, advance those stated interests, given the record before the Court. Consequently, the Subject Laws fail strict scrutiny and are unconstitutional infringements of pregnant women's, including the plaintiffs' patients, rights bestowed by Section 1 of the Kansas Constitution's Bill of Rights.

C. The Subject Laws Violate the Provider plaintiffs' Fundamental Rights Enshrined in Section 11 of the Kansas Constitution's Bill of Rights (Free Speech).

Provider plaintiffs also successfully demonstrate that the Subject Laws violate their fundamental rights to "free speech," as guaranteed by Section 11 of the Kansas Constitution's Bill of Rights, and the State Defendants have failed to prove that the legislative schemes survive constitutional scrutiny.

Insofar as the Subject Laws dictate the nature and extent of specific non-discretionary communications by providers, the Subject Laws infringe on the Provider

plaintiffs' fundamental rights to freedom of speech, which includes the right ***not*** to speak. The Subject Laws regulate the content of speech for *only* this limited group of providers, and they do so, not to broadly regulate medical professional conduct, but rather, to simply dictate and change the content of plaintiffs' speech to conform to the State's viewpoint preference. In other words, the Subject Laws are, at a minimum, content-based schemes that necessarily alter the substance of the providers' speech. As such, the Subject Laws unconstitutionally encroach upon the confidential and close relationship between medical providers that provide abortions and their patients. More specifically, they infringe upon the providers' speech, as it relates to specific informed consent discussions. In doing so, the Subject Laws simply do not survive the applicable strict-scrutiny review.

1. Applicable law governing Section 11 claims.

Much like Section 1 of the Kansas Constitution's Bill of Rights, Section 11 likewise presents similar, but not identical, language to that set forth in the United States Constitution's Bill of Rights. Specifically, Section 11 provides:

> "The liberty of the press shall be inviolate; and ***all persons may freely speak, write or publish their sentiments on all subjects,*** being responsible for the abuse of such rights."

Kan. Const. Bill of Rights, § 11 (emphasis added).

Kansas likewise considers the freedom of speech, pursuant to Section 11, to be "among the most fundamental personal rights and liberties of the people," *League of Women Voters of Kansas v. Schwab*, 63 Kan.App.2d 187 (2023) (citing *U.S.D. No. 503 v. McKinney*, 236 Kan. 224, 234, 689 P.2d 860 (1984)). It is "'generally considered coextensive'" with the right as protected under the First Amendment to the United States

Constitution. *Prager v. Kansas Dept. of Revenue*, 271 Kan. 1, 37, 20 P.3d 39 (2001) (citation omitted); *State v. Russell*, 227 Kan. 897, 899, 610 P.2d 1122 (1980); *League of Women Voters of Kansas v. Schwab*, supra. The parties have not proffered, nor has this Court found, binding precedent that dictates any meaningful distinctions between Section 11's protections and those afforded under existing First Amendment precedent. The Court proceeds accordingly.

[A]ll speech inherently involves choices of what to say and what to leave unsaid . . . .'" *Hurley v. Irish-Am. Gay, Lesbian & Bisexual Grp. of Bos., Inc.*, 515 U.S. 557, 573, 115 S. Ct. 2338, 132 L.Ed.2d 487 (1995). "Freedom of speech" protects both of these choices. *American Medical Assoc. v. Stenehjem*, supra at 1148 (citing *Wooley v. Maynard*, 430 U.S. 705, 714, 97 S.Ct. 1428, 51 L.Ed.2d 752 (1977) (free speech includes "both the right to speak freely and the right to refrain from speaking at all.); see also *Chiles v. Salazar*, 607 U.S. ---- 146 S.Ct. 1010 (2026) (invalidating laws regulating therapists' ability to discuss "conversion" therapy with minors because the laws violated the "free speech" rights of a therapist and failed "strict scrutiny"); *NIFLA v. Becerra*, 585 U.S. 755, 138 S.Ct. 2361, 201 L.Ed.2d 835, (2018) ("crisis pregnancy centers" First Amendment rights violated by state-mandated messaging requirements regarding pregnancy options and resources).

Though freedom of speech is considered a fundamental right, it is not boundless. There are instances when the government can permissibly regulate speech and expressive conduct. Perjury, blackmail, true threats, and defamation are all afforded little, if any, protection under the federal or state constitutions. *United States v. Alvarez*, 567 U.S. 709, 717-18, 132 S. Ct. 2537, 2544, 183 L. Ed. 2d 574 (2012) (plurality

opinion); *League of Women Voters of Kansas*, supra at 790. And commercial speech, in general, is also less protected—meriting only "intermediate scrutiny." See *e.g. Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio*, 471 U.S. 626, 6317-38, 105 S.Ct. 2265, 2274-75, 85 L.Ed.2d 652 (1985) (describing commercial speech framework—"truthful and non-misleading"). Similarly, laws that specifically regulate conduct but that may incidentally burden speech often also qualify for the lighter touch of intermediate scrutiny. *City of Wichita v. Trotter*, 58 Kan. App. 2d 781, 791, 475 P.3d 365, 375 (2020) (content-neutral restrictions that incidentally regulate both expressive and non-expressive conduct are subject to less exacting review); *Chiles*, supra at 1022; *NIFLA*, supra at 2372-2376.

In most other circumstances, the permissibility of government regulation of speech depends on whether an attempted regulation is content-based or content-neutral. Both federal and Kansas precedent distinguish content-based regulation from content-neutral regulation and apply distinct standards for each category of regulation. Content-based regulation "targets speech based upon its communicative content." *Reed v. Town of Gilbert*, 576 U.S. 155, 163, 135 S.Ct. 2218, 2226, 192 L.Ed.2d 236 (2015) (whether subject matter or viewpoint); see also *Wagner v. State*, 46 Kan.App.2d 858, 867 (2011) ("[r]egulations that control speech, that is the message itself, are content-based."). These types of laws either discriminate on their face, by "draw[ing] distinctions based on the message a speaker conveys" or in their application, if they, though facially content-neutral, "cannot be justified without reference to the content of the regulated speech" or "because of disagreement with [what] the message conveys." *Reed*, 576 U.S. at 164 (quoting *Ward v. Rock Against Racism*, 491 U. S. 781, 791

(1989)). Because “[m]andating speech that a speaker would not otherwise make necessarily alters the content of the speech,” speech compelled by the government is typically considered content-based regulation. See *Riley v. Nat’l Fed’n of the Blind of N.C., Inc*., 487 U.S. 781, 795, 108 S.Ct. 2667, 101 L.Ed.2d 669 (1988).

Content-based laws, whether facially or in application, are subject to strict scrutiny and are presumed unconstitutional, regardless of the government's benign motive, content-neutral justification, or the lack of “animus toward the ideas contained” in the regulated speech. *Reed*, supra at 165; *Riley*, supra at 795; see also *NIFLA*, supra at 2371, 201 L.Ed.2d 835 (2018) (content-based laws are subject to strict scrutiny); see also *Ward v. Rock Against Racism*, 491 U.S. 781, 791, 109 S.Ct. 2746, 105 L.Ed.2d 661 (1989) (laws that cannot be “justified without reference to the content of the regulated speech” or that were adopted by the government “because of disagreement with the message [the speech] conveys,” must satisfy strict scrutiny.) And although both content-based and viewpoint-based regulations are subject to this rigorous standard, the latter is considered a “particularly egregious form” of content regulation. *Chiles*, supra at 1021, 1029.

Indeed, laws or regulations that discriminate based upon viewpoint and seek to dictate what particular “opinion or perspective” individuals may express on a subject present “even greater dangers” from this “egregious form” of content regulation, which is why “governments in this country must nearly always ‘abstain’ from it.” *Chiles*, supra at 1021 (citations omitted). The *Chiles* court has noted:

> “When the government seeks not just to restrict speech based on its subject matter, but also seeks to dictate what particular “opinion or

> perspective" individuals may express on that subject, 'the violation of the First Amendment is all the more blatant.'"

Id. (citing *Rosenberger v. Rector and Visitors of Univ. of Va.*, 515 U.S. 819, 829, 115 S.Ct. 2510, 132 L.Ed.2d 700 (1995)). Laws/regulations that draw a line based on the "ideology" of the speaker—disadvantaging one view and advantaging another—skew the marketplace of ideas our society depends on to discover truth. *Rosenberger*, supra at 829. And such regulatory schemes are largely indicative of an impermissible motive—that the government is regulating speech because of its own "hostility" toward or affinity for the targeted messages. See *R. A. V. v. St. Paul*, 505 U.S. 377, 386, 112 S.Ct. 2538, 120 L.Ed.2d 305 (1992); see also *NIFLA*, supra. If the First Amendment prohibits anything, it is the "official suppression of ideas." *Id.*, at 390, 112 S.Ct. 2538; see *Reed v. Town of Gilbert*, 576 U.S. 155, 181–183, 135 S.Ct. 2218, 192 L.Ed.2d 236 (2015) (KAGAN, J., concurring in judgment). Because viewpoint-based laws always raise that specter, they are the most suspect of all speech regulations.

Conversely, content-neutral regulations are those which confer benefits or impose burdens upon speech without reference to their content and that, if they implicate speech at all, regulate it only ***incidentally*** to an unrelated government purpose. See *Turner Broad. Sys., Inc. v. F.C.C.,* 512 U.S. 622, 643, 114 S. Ct. 2445, 2459, 129 L. Ed. 2d 497 (1994); see also *Ward v. Rock Against Racism*, 491 U.S. 781, 791, 109 S. Ct. 2746, 2754, 105 L. Ed. 2d 661 (1989) ("Government regulation of expressive activity is content neutral so long as it is "justified without reference to the content of the regulated speech."); *Wagner v. State*, 46 Kan. App. 2d 858, 867, 265 P.3d 577, 584 (Kan. App. 2011) (holding that regulation was "content neutral" when it did not compel, control, bar, or limit free speech but may incidentally burden some speech).

Recognizing the reality that some circumstances may warrant limitations on freedom of speech, content-neutral laws that only *incidentally* impact speech are subject to the less-rigorous intermediate scrutiny framework. *City of Wichita v. Trotter*, 58 Kan. App. 2d 781, 791, 475 P.3d 365, 375 (2020) (content-neutral restrictions that incidentally regulate both expressive and non-expressive conduct are subject to less exacting review); *Chiles*, supra at 1022; *NIFLA*, supra at 2372-2376. Content-neutral regulations resulting in restrictions on speech will be upheld if the restriction is *truly* incidental, is no greater than essential to further an important or substantial government interest unrelated to the suppression of free expression, and if the regulation itself was within the government's power to enact. *Trotter*, supra at 791. (citing *United States v. O'Brien*, 391 U.S. 367, 377, 88 S. Ct. 1673, 20 L. Ed. 2d 672 (1968)).

But, importantly, "an innocuous justification cannot transform a facially content-based law into one that is content neutral." *Reed v. Town of Gilbert, Ariz.*, 576 U.S. 155, 166, 135 S. Ct. 2218, 2228, 192 L. Ed. 2d 236 (2015).

2. The Subject Laws are not exempt from traditional First Amendment analysis and cannot be re-labeled as content-neutral regulation of mere conduct.

a. The State Defendants' arguments for a new exempt category of "professional medical regulation" fail.

The State Defendants argue that the WRTKA ""regulates professional conduct, not speech." Pretrial Order, Index No. 630; pg. 7. And, for what it's worth, they have also articulated that the provisions of the WRTKA are "truthful and non-misleading." See *Id.* at pg. 46, 50. The State Defendants further contend that the Reason Mandate is merely garden-variety "public health surveillance" and, thus, a permissible regulation.

See *Id.* at pg. 7, 27. As a result, they insist that the Subject Laws are permissible and appropriate content-neutral regulations of physicians that perform abortion, suggesting that they have a rational basis.

In support of their arguments, the State Defendants appear to assert a new category of regulation exempted from traditional First Amendment analysis, based upon a murky blend of standards: some hybrid of the *Casey* "undue burden" standard and subsequent dicta from *NIFLA,* which discussed whether the compelled speech required anything more or less than "truthful and non-misleading" information.[50] See Pretrial Order, Index No. 630; pg. 7, 46, 50; Trial Tr. vol. VII (PM), 101: 16-24 (Nussbaum). Hence, they appear to argue that, in light of the holdings in *Casey* and *NIFLA*, the Subject Laws must be upheld, unless they are "false and misleading" because they merely "regulate conduct" of the professionals, who are licensed by the State. See Pretrial Order, Index No. 630; pg. 46, 50; Trial Tr. vol. VII (PM)101:16-14) (Nussbaum).[51]

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[50] It appears that the State Defendants may be arguing, albeit less than directly, that *NIFLA* and *Casey* established an additional broad exemption from strict scrutiny for **any** substantive informed consent law, insofar as they contend that plaintiffs must demonstrate that the Subject Laws either are false and misleading OR are unrelated to a medical procedure that the plaintiffs provide. See Pretrial Order, Index No. 630; pg. 46, 50. The Court believes the State Defendants paint with too broad a brush and ascribe too much significance to language from *Casey*, which is now far less relevant in Kansas, given the *Hodes* decisions addressing Section I fundamental rights. Nothing in either *Casey* or *NIFLA* suggests a new and distinct exception to (or departure from) traditional First Amendment analysis for medical professional regulation. In point of fact, the Court expressly reiterated that the well-established free-speech framework and exceptions apply to professionals, including medical professionals. See *Chiles*, supra at 1023 ("Nor, we emphasized, do these narrow categories of lesser-protected speech warrant a new rule exempting a broader "category called 'professional speech'" from demanding First Amendment review.")

[51] Counsel further argued in closing that the Reason Mandate is valid because "it is the State asking questions" Trial Tr. vol. VII (PM), 105:7-9 (Nussbaum) and is tantamount to a "voluntary data collection" that qualifies as basic "public health surveillance." See Pretrial Order, Index No. 630; pg. 27. The problems with this argument are myriad. For example, the Reason Mandate is simply not "the State asking" anything. Rather, it is a governmental mandate that a unique and limited subset of health care providers, who offer to provide a service disfavored by the State, question their patients about highly personal and sensitive issues and interrogate their patients regarding the "most important reason" for their health care choices, without any articulated justification whatsoever. If it is, as counsel suggests, "the State asking" questions through mandates to third parties, it is quintessential content/viewpoint-

The Court rejects both the State Defendants' arguments embracing some new hybrid standard derived from *Casey/NIFLA* language and their suggestion that some level of review[52] other than strict scrutiny applies to free speech claims in this context under Kansas law.

Casey largely adopted an "undue burden" standard as the framework for future review of abortion regulation under *federal law*. While the Justices spent most of their time and "ink"[53] addressing the privacy claims brought on behalf of pregnant patients, Justice O'Connor's primary/majority opinion also addressed, albeit in a cursory and summary manner,[54] the providers' claims asserting free speech claims. See *Casey*, supra at 883-84. But a closer reading of the *Casey* opinions actually confirms the Court's recognition that traditional First Amendment analysis applies to medical professional speech. Notably, that primary opinion expressly observed that physicians'

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based compelled speech. And the evidence was clear that the statute neither reflects "public health surveillance" nor a "voluntary" data collection gathered for any particular purpose—much less for some compelling (or even important) purpose aimed at addressing an ***actual problem***, the existence of which is supported with evidence in the record.

[52] Again, the State Defendants are, at best, equivocal as to what the applicable level of scrutiny is that must be applied to the Subject Laws. They suggest, at times, that the standard is largely "rational basis". See Pretrial Order, Index No. 630, pg. 7 (subparagraph g). But they also contend they nonetheless survive strict scrutiny, as an alternative position. See *Id.* Notably, they largely ignore that cases addressing regulation of "professional conduct" that *incidentally* burden speech consistently apply an *intermediate scrutiny* standard.

[53] The majority holding and decision is comprised of several opinions that comprised a "majority," in terms of result, but multiple Justices authored concurring and dissenting opinions, expressing differing views on a number of the specifics and nuances contained within Justice O'Connor's primary opinion.

[54] The O'Connor joint opinion in *Casey* actually seems to employ no true analysis whatsoever for First Amendment purposes, instead characterizing the providers' rights and status as "derivative" of the pregnant woman's rights. See *Casey*, supra at 884. Justice O'Connor then went on to merely find that the regulations at issue were not, on the record before that Court, an "undue burden," as contemplated with respect to the women's privacy rights. The decision gave short shrift to any separate First Amendment analysis, such as the arguments made herein. Thus, this Court does not find that the *Casey* language addressing the First Amendment speech claims in that case to be particularly insightful and certainly not binding on the issues raised herein.

First Amendment rights can be implicated by State regulation of speech-implicated medical-practice issues such as informed consent, but it noted that regulation of medical professionals, including those requiring informed consent, are simply "no different" for constitutional purposes. *Casey*, supra at 884. In other words, the normal analysis and rules apply.

True, the *Casey* court found no First Amendment violation of the physicians' rights *on that record*, but notably, the statute involved there was, in many respects, materially and dramatically different, in terms of the content and obligations. *Id.* at 884; *Id.* at 902 (App. to Opinion of O'Connor, Kennedy, and Souter, JJ). From a content standpoint, the Pennsylvania statute was far less onerous, content-driven, ideologic, and aimed at influencing a woman's decision. *Id.* Further, the Pennsylvania law implicated in *Casey* afforded broad discretion to providers to decline to comply with the statutory written substantive "informed consent" requirements. *Id.* at 883. Consequently, any suggestion that *Casey* applies here and provides binding authority that broadly exempts "informed consent" laws from traditional First Amendment analysis is simply not meritorious.

Indeed, *NIFLA* further clarified and indicated that long-standing First Amendment precedent does **not** recognize a categorical exemption for "professional speech" from strict scrutiny. See *NIFLA*, supra at 2372, 2374 ("Outside of the two contexts discussed above, [ ] this Court's precedents have long protected the First Amendment rights of professionals."). This is true even if the law at issue is based upon a premise that the government is merely regulating "professional conduct." *Id.* Instead, the *NIFLA* Court again reiterated that, for First Amendment purposes, a content-neutral regulation cannot

do more than "incidentally burden" speech, in order to qualify for the less-exacting "intermediate scrutiny" standard. *Id.* at 2373. Otherwise, it is subject to the traditional strict-scrutiny analysis, where the regulation involves either content-based regulation, on its face or by application, or a more sinister related form of regulation, viewpoint regulation.

And these broad principles were recently re-affirmed by the Court in *Chiles. Chiles v. Salazar*, 607 U.S. –, 146 S.Ct. 1010 (2026). As a notable introductory comment, the Court stated:

> "In this Nation, no official—"high or petty"—may command our tongues or silence our voices."

Id. at 1021 (citing *West Virginia Bd. Of Ed. v. Barnette*, 319 U.S. 624, 642, 63 S.Ct. 1178, 87 L.Ed. 1628 (1943)). And the Court expressly noted:

> "our precedents have expressly rejected the . . . . notion that 'professional speech' represents some 'separate category of speech' subject to 'diminished constitutional protection."

Id. at 1024. The Court further recognized a long history of "official efforts" to manipulate and control professional speech and "muzzle" professionals in an effort to increase state power and perspective. *Id.* For those very reasons, the Court expressly rejected virtually-identical arguments to those that the State Defendants assert herein, finding that the argument "stumbles out of the gate" because such a "First Amendment Free Zone" would permit:

> "States [to] censor almost any speech they consider 'substandard care.' It is, once more, an approach our precedents already foreclose."

Id. at 1027. Simply stated, any argument or suggestion that content-based regulation of medical professionals, even those broadly labelled as "informed consent" laws, are

exempt from normal First Amendment analysis simply gains no traction in either Kansas or federal "free speech" case law.

Thus, consistent with Kansas "free speech" law derived from Section 11 of the Kansas Constitution's Bill of Rights, and with parallel federal authority involving a coextensive federal right, this Court will review the Subject Laws under the traditional First Amendment framework, as described above, particularly because the Subject Laws do not fall within the purview of the recognized exception for content-neutral laws that regulate conduct but that may *incidentally* burden speech in that process.

b. The Subject Laws are not mere regulation of "conduct" that "incidentally" burdens speech.

While medical professionals, like all professionals, broadly retain First Amendment protections, there is a recognized exception for governmental regulations that are content neutral and govern "conduct," while only incidentally burdening speech.[55] See discussion, IV.C.2, supra. However, the Subject Laws simply do not fit within this exception.[56]

[55] A second exception to strict scrutiny exists for regulation of "commercial speech" that requires the provision of "factual and noncontroversial" data to a consumer. See *Zauderer v. Office of Disc. Counsel of Ohio,* 471 U. S. 626, 651, 105 S.CT. 2265 (1985). However, the State Defendants do not rely on or point to this exception, and the Court concludes it doesn't apply, regardless. Indeed, the disclosures required by the WRTKA are anything but "factual and noncontroversial".

[56] If this exception applied, it would dictate the use of intermediate scrutiny, not rational basis, to review their permissibility. See *City of Wichita v Trotter*, supra at 375; *Chiles*, supra at 1022-23; *NIFLA*, supra at 769; *VoteAmerica v. Schwab*, 121 F.4th 822, 848 (10th Cir. (Kan.) 2024) ("content-neutral regulations of speech—i.e., regulations justified without reference to the content of the regulated speech—must meet intermediate scrutiny.").

First, both the WRTKA and its supplement, the APR Mandate, do not broadly regulate conduct of medical professionals in some generally-applicable and content neutral way. As the Court in *NIFLA* astutely pointed out:

> "States cannot choose the protection that speech receives under the First Amendment [by imposing a licensure requirement], as that would give them a powerful tool to impose 'invidious discrimination of disfavored subjects."

NIFLA, supra at 2376.

The WRTKA's purpose (as well as the specific APR Mandate supplement) is not, at least on its face, to "uphold the integrity of the medical profession," through generalized regulation of the provision of "informed consent" by the profession as a whole or even through written confirmation of "informed consent" that comports with established and well-recognized professional standards of care.[57] Instead, and as discussed below (see Section IV.C.3, infra), the Laws' purposes are unequivocally to regulate, through State-scripted governmental mandate, a limited group of medical professionals, with respect to one specific aspect of their professional speech on one singular type of healthcare that the State considers disfavored or problematic. It is exactly the same type of regulation reflecting "invidious discrimination of disfavored subjects" that the *NIFLA* Court rejected. Consequently, they are the definition of content-based legislative action.

And even if it were the relevant legal standard and analysis (it is not), it cannot be reasonably argued that the WRTKA (or the APR Mandate) are merely requiring

[57] Even if it could be described in such a content-neutral fashion, the unavoidable application demonstrates the content and speaker-based nature that requires strict scrutiny. "[A]n innocuous justification cannot transform a facially content-based law into one that is content neutral." *Reed v. Town of Gilbert, Ariz*., 576 U.S. 155, 166, 135 S. Ct. 2218, 2228, 192 L. Ed. 2d 236 (2015).

"informed consent" by disseminating only "truthful and non-misleading" information that relates to a procedure specifically. They don't. As detailed in the Court's findings and conclusions above, significant portions of the written disclosures mandated by the WRTKA are inaccurate and/or misleading (over 30%, according to the testimony and evidence), and rather than informing the patients' autonomous consent, it seeks to influence that process. The APR Mandate suffers from the same malady because it presents an unproven and potentially-dangerous theory to pregnant women contemplating an abortion as "fact" and necessarily misleads them. See discussion IV.B.5.b., supra.

Further, the Laws mandatory notifications do not even limit their reach specifically to a procedure or to the target audience for those considering abortion care. Indeed, the signage requirements of both the WRTKA and the APR Mandate, which must be posted "conspicuously" in waiting rooms and exam rooms, create universal conditions for all present within the premises—regardless of why they are there or whether they receive any healthcare at all. As a result, all patients and other individuals present at the plaintiffs' offices are subjected to this information/misinformation, regardless of their healthcare needs. This type of mandated speech was expressly prohibited in *NIFLA* because it violated the "licensed" provider's First Amendment rights. See *NIFLA*, supra at 2373-74. In short, the WRTKA and its supplement, the APR Mandate, are a far cry from uncontroversial content-neutral regulations aimed at improving the medical profession, in general, by requiring some confirmation that the patient has been provided with basic information on risks, benefits, and reasonable alternatives to

healthcare procedures, as required by the professional standards of care and common law in Kansas.

And, even if one could reasonably argue that the WRTKA and APR Mandate fell into a category of a basic and broadly-applicable "informed consent" laws to improve the medical profession, these laws simply don't have an **incidental** impact on speech—they have a direct and intended impact on speech. That is to say, these laws simply regulate speech as speech and require the provision of legislatively-selected content that corresponds to the State's viewpoint. It cannot be reasonably argued that a law requiring specific and detailed substantive information chosen solely by the State, which must be provided at specific times and in specific formats, most or all of which would not otherwise be included by professional and common-law standards, only "***incidentally***" burdens the normal informed consent discussion of this small group of health care providers. The burden could not be more direct on the Provider plaintiffs' speech, and the overwhelming evidence supports this conclusion.

There is a real difference between laws directed at conduct that sweep up speech "incidentally," and laws that directly regulate speech and its content. And the government cannot regulate speech by simply relabeling it as "conduct." See *NIFLA*, supra at 2373 (noting that "a State may not, under the guise of prohibiting professional misconduct, ignore constitutional rights.") (citing *NAACP v. Button*, 371 U.S.415, 439, 83 S.Ct. 328 (1963)). Given this record, it cannot be reasonably disputed that the WRTKA and APR Mandate ***directly*** burden the providers' speech during their confidential and intensely personal and private discussions with their pregnant patients. And the laws require those providers to either speak the State's selected message, at the expense of

their own viewpoints and professional medical judgment, or to risk personal and professional consequences. The WRTKA and the APR Mandate simply do not merit the lighter touch of an "intermediate scrutiny" standard because they are not conduct-neutral laws that only ***incidentally*** burden speech.

3. The Subject Laws cannot survive strict scrutiny because the State Defendants have failed to meet their burden of proof.

a. The WRTKA and the APR Mandate are content-based laws.

In this case, there can be no legitimate question that the Subject Laws are, at least, content-based regulations[58] and presumptively unconstitutional. The WRTKA (including the APR Mandate) compels the Provider plaintiffs and similarly-situated providers to speak a particular message that the State has crafted and embraces. That message goes well beyond what the applicable standard of care requires in Kansas to provide valid informed consent for each individual patient. Notably, standard "informed

[58] The Subject Laws almost certainly constitute viewpoint-based laws that seek to prescribe the State's preferred message regarding abortion and childbirth, amongst other substantive topics (such as, for example, morality/spirituality/philosophically-based statements regarding abortion terminating a "whole, separate, unique, living human being"). In doing so, they infringe upon the rights of providers to conduct unbiased, non-judgmental, medically accurate, material, and candid conversations with their pregnant patients. Similarly, the WRTKA mandates that providers notify abortion patients that "many agencies are willing to provide assistance so that you may carry your child to term and to assist you after the child's birth." See K.S.A. 65-6709 (b), (k) (2024). Relatedly, the APR Mandate requires disclosure of the speculative and unproven theory of "abortion reversal." K.S.A. 65-6716 (b), (c) (2024). These types of disclosures are undeniably viewpoint discriminatory. They very clearly place the State's figurative finger on the scales of the decision-making process, which is a hallmark of viewpoint discrimination. See *Chiles*, supra at 1021 (citing *Rosenberger v. Rector and Visitors of Univ. of Va.*, 515 U.S. 819, 829, 115 S.Ct. 2510, 132 L.Ed.2d 700 (1995)). At the core, the State Defendants seek to "dictate what 'opinion or perspective' individuals may express" on this particular subject through application of the now-exhaustive WRTKA provisions. See *Chiles*, supra at 1021. And, as mentioned, they do so in contravention of what the evidence largely reflects is mainstream medical consensus on such topics. It is of no matter that the WRTKA or the APR Mandate would thereafter permit a doctor to caveat these mandatory disclosures with "and I disagree with these statements, which are required by the State." Such disclaimers don't change the conclusion that the WRTKA alters the providers' speech, dictates the mandated viewpoint, and injects inherent conflict into a trust-based relationship that depends upon candid and non-judgmental conversations between the patient and the healthcare provider. Regardless, the conclusion that these laws are viewpoint discriminatory is unnecessary to the Court's conclusions, as there is zero question that they constitute content-based laws and are necessarily subject to strict scrutiny.

consent" obligation already exists in Kansas for all health care providers, consistent with established Kansas common law. [59] And, beyond that, there are existing and robust legal and administrative "backstops" to ensure that health care providers, including those that provide abortion care, are obtaining "informed consent" from their patients, as required by (and consistent with) their medical and professional judgment and the applicable standard of care. See FOF, ¶¶ 5-7, 55, 62-67.

Nevertheless, the Act requires the "physician who is to perform the abortion" to affirmatively disclose, at least 24 hours in advance,[60] in writing, and, in part, on

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[59] Informed consent, as contemplated under Kansas law, arises from an initial premise, as the Supreme Court in *Hodes I* noted, of:

> "thorough-going self determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment."

Hodes I at 643 (citing *Natanson v. Kline*, 186 Kan. 393, 406-07 (1960)). Towards that end, Kansas law has long held that "informed consent" does *not* require a disclosure of all risks of a contemplated therapy or medical procedure, no matter how remote or tangential, but rather those disclosures that a "reasonable medical practitioner would make under the same or similar circumstances." *Natanson*, supra at 409-410; see also *Collins v. Meeker*, 198 Kan. 390, 397 (1967). In other words, "informed consent" requires the disclosure of "material" information, as deemed appropriate by a reasonable practitioner exercising his/her own professional judgment. See *Id.*; see also *Acuna v. Turkish*, 930 A.2d 416, 428 (N.J. 2007)(holding that informed consent required practitioners "to provide their pregnant patients seeking an abortion only with ***material medical*** information"). Kansas law has never required (of any practitioner or subspecialty) disclosure of "any and all results which might possibly follow a medical or surgical procedure." See *Tatro v. Lueken*, 212 Kan. 606, 616 (1973). Invariably, informed consent by a medical professional involves primarily a question of medical judgment by the provider. *Natanson*, supra 409-410.

[60] The Act makes it incumbent upon those specific providers that are "to perform the abortion" to document the date and time the consent forms are reviewed and executed by a patient, in order to affirmatively demonstrate compliance with the Act and to avoid potential civil, criminal, or administrative sanction. While the State Defendants suggest that this methodology and process is a "choice" of the provider, it is not. Absent some documented method to verify the timing, plaintiffs would risk exposure to these very harms, and the Act affirmatively requires time-stamping in other respects. See K.S.A. 65-6709((h)(5), (i)(4). To the extent that the State Defendants argue that these provisions do not effectively impose statutory mandates or requirements, the Court rejects their suggestion.

specifically-formatted signed consent form documents, [61] medically irrelevant,

inaccurate, misleading, and potentially stigmatizing data, including:

- Detailed but medically-irrelevant information about the physician performing the abortion (including, state of residence; names of hospitals where the physician either maintains or has "lost"[62] clinical privileges; the existence of malpractice insurance;[63] etc.);
- Alarmist, inaccurate, one-sided and/or misleading information regarding purported increased risks of breast cancer, future risk of preterm birth, and other purported "reproductive" risks stemming from abortion, which fall outside the medically relevant and material risks of the procedure;
- Contact information regarding counseling for parents receiving fetal abnormalities; perinatal "hospice" services, and lists of websites for "national perinatal assistance";
- Affirmative statements that medical assistance benefits may be available for prenatal care, childbirth, and neonatal care;
- Affirmative counseling of patients that further information is available, in written form and online, listing "alternatives to abortion, with a special section listing adoption services and list providers of free ultrasound services;"[64]
- Affirmative statements regarding child support obligations of the biological father, except in cases of rape;[65]

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[61] The written consent form document with the Act's mandated disclosures is to be on particular paper in a particular typeset/font and in a particular size font and in black ink. As discussed in the Court's findings, this complex procedural requirement clearly results in delays and/or denials of care and infringes on patients' fundamental rights. But, even reducing some of the formatting particularities does not wholly eliminate the infringement, given the overwhelming evidence presented at trial as to the hurdles imposed, along with the mandatory delays that are conditions precedent to the exercise of the patients' rights. In fact, the evidence presented as to the post-injunction time period demonstrates the seriousness of the infringement and the ameliorative effect when the patients need not traverse the lengthy and confusing procedural labyrinth to obtain the care they seek. FOF ¶¶ 183-93, 216-228.

[62] Whether voluntarily or involuntarily.

[63] All healthcare providers in Kansas, pursuant to the Healing Arts Act, are required to maintain minimum malpractice liability insurance. See K.S.A. 40-3402 (2025) and its prior versions.

[64] These types of requirements are strikingly similar to the type of viewpoint-targeting notices that were invalidated by the Supreme Court in *NIFLA* because they infringed the providers' rights to free speech. The fact that they reflect the converse of the content is of no import to a Section 11 free-speech analysis.

[65] How logistically a provider is supposed to address this is unclear, without having a separate version of the form available for victims of rape. This would obviously require the physician to know whether the exception might apply to a particular patient, in advance of the actual appointment by at least 24 hours. Otherwise, the normal consent form and affirmative statements would presumably need to be used to comply with the Act's requirements. And the Act's academic exception is empty solace where the physician is only told that the patient is a victim of such a crime **after** the "consent" form and disclosure is provided.

- Affirmative statements of a moral, spiritual, or philosophical nature that the abortion "will terminate the life of a whole, separate, unique, living human being;"
- Affirmative and, at best, misleading statements that, by no later than 20 weeks from fertilization [22 weeks LMP], the unborn child has the physical structures necessary to experience pain, along with other affirmative but misleading statements regarding fetal movements that the State equates to conscious volitional response from the fetus and regarding the purported use of fetal anesthesia during fetal surgery;
- Additional and lengthy (over 20 pages prior to the Court's Temporary Injunction) State-mandated written materials (pursuant to K.S.A. 65-6710) to be provided by the physician or his/her agent to the patient, which include the following statement: "***Many public and private agencies exist to provide counseling and information on available services. You are strongly urged to seek assistance from such agencies in order to obtain guidance during your pregnancy. In addition, you are encouraged to seek information on alternatives to abortion, including adoption, and resources available to postpartum mothers***. The law requires that your physician, or the physician's agent, provide this information";[66]
- Affirmative but inaccurate and/or misleading information on fetal development at two-week intervals through the time of childbirth;
- Affirmative and detailed information about adoption law and process for an "untimely pregnancy";
- Affirmative and detailed information on Kansas child support law; and
- Affirmative and detailed information on Kansas parentage/paternity law.

See FOF, ¶¶ 10-31, 194-215.

Pursuant to the APR Mandate, the WRTKA further requires providers to disclose, both personally (in person or over the telephone) and in writing, at least 24 hours prior to a medication abortion:

- That "it may be possible to reverse the intended effects of a medication abortion that uses mifepristone, if the woman changes her mind, but that time is of the essence";
- That there is information on the "reversal" process is available from the State on KDHE's website; and

[66] See note 64, supra. Much like *NIFLA*, the State seeks to compel providers to simultaneously engage in their normal informed consent disclosures under the standard of care with their abortion patients and to affirmatively provide them with information to dissuade them from undergoing the very care that they seek. Thus, the WRTKA, much like the licensed notice in *NIFLA*, "alters the content" of the providers' speech. See *NIFLA*, supra at 2371.

- Affirmative disclosures on “other relevant telephone and internet resources” on APR theory.

The same information must then be provided, another time, *after* administration of Mifepristone, in a written notice. FOF, ¶¶ 31-37.

The Act further requires that the providers post, in a “conspicuous location” within their offices that is “clearly visible to patients,” “giant” signs (separate signs for both the existing WRTKA and the supplemental APR Mandate), with much of the substantive information identified above disclosed yet again to ***all patients and occupants*** of the providers’ offices, regardless of their reason for being there. FOF, ¶¶ 28, 33, 224. Indeed, the APR Mandate signs are required for private offices/clinics in every patient waiting room and exam room where medication abortions may be performed. See K.S.A. 65-6716(b) (2025).

The evidence was unequivocal at trial that the providers would not, absent the regulatory requirements established by the WRTKA and APR Mandate, provide disclosures of this kind when engaging in their traditional informed-consent discussions with patients, in conformity with the established professional standard of care. FOF, ¶¶ 71, 73, 116-118, 143-157, 193-228.

Inevitably, the WRTKA creates a tragic problem for providers and, correspondingly, for their patients. Namely, it obligates providers, such as the plaintiffs, to participate in obfuscating the medically-relevant and necessary data a pregnant woman contemplating an abortion should have by first providing them with the voluminous, ideologic, repetitive, and often inaccurate or misleading information mandated by the State. How do providers convey to their pregnant patients considering

an abortion with meaningful distinctions between the information their medical training and professional judgment determines to be material for the particular patient from the State's obligatory messaging, which is designed to persuade patients to conform their choice to the State's preference? And how do patients navigate the same? This conflict unequivocally demonstrates the altered nature of the providers' speech and reveals the content-based and/or viewpoint-based nature of the Act's mandatory disclosures.

Indeed, the plaintiffs' detailed testimony as to how the Act's requirements did and would change the content of their desired speech, along with the problems raised under such scenarios, was both credible and compelling to the Court. The plaintiffs' witnesses made it clear that they would not, absent the WRTKA's requirements and the specter of available attendant punishments (some civil, some criminal, and some administrative/disciplinary),[67] categorically provide this data—either in whole or in part—to their patients, for any number of credible reasons. FOF, ¶¶ 193-94, 206, 216-28. They further testified convincingly to their opinions regarding the inaccurate, misleading, and medically-irrelevant nature of much of the material required by these schemes. See generally, FOF, ¶¶ 194-215. Indeed, it was their collective experiences that this type of voluminous disclosure confused and undermined "informed consent" for their patients and disrupted their professional relationship by creating conflict, distrust, and uncertainty within their patients. FOF, ¶¶216-22, 227-28. And the required disclosures largely did not inform or alter their decisions. FOF, ¶¶ 73, 214, 216-20, 228.

[67] In this regard, the WRTKA, along with its supplement, the APR Mandate, create a proverbial "Sword of Damocles" hanging over the physician providers' (including plaintiffs) respective heads, given the criminal, civil, and administrative penalties that lie waiting for them, if they were to exercise their professional medical judgment and refuse to act as a messenger for the State's preferred viewpoint and message.

Further, Dr. Nauser as well as Comprehensive Health staff, some of the very few available providers for care of this type, unequivocally testified that they would stop providing medication abortions altogether, if they were required to provide the APR Mandate's disclosures. FOF, ¶¶206, 225. This is because of their firm belief, guided by mainstream obstetrical practice and knowledge, as to the scientific inaccuracy and risks posed by those particular mandated APR disclosures. *Id.* See also *Hurley v. Irish-Am. Gay, Lesbian & Bisexual Grp. of Bos*., 515 U.S. 557, 573, 115 S. Ct. 2338, 2247, 132 L. Ed. 2d 487 (1995) (the government "may not compel affirmance of a belief with which the speaker disagrees" and a speaker's "right to tailor the speech, applies not only to expressions of value, opinion, or endorsement, but equally to statements of fact the speaker would rather avoid."); *NIFLA*, supra at 775, 2376 (the State "cannot co-opt licensed facilities to deliver its message for it.").

It is clear that the WRTKA and the APR Mandate has (or would, if required) very distinctly altered the nature of the Provider plaintiffs' speech through the statutory obligations and potential significant ramifications for them, as providers. As such, there can be little doubt that the WRTKA and its supplemental APR Mandate are content-based regulations that directly target a particular topic that the State expressly disfavors (the choice to terminate a pregnancy), given the statutory scheme's plain language.

b. The Reason Mandate is also a content-based law.

Similarly, the Reason Mandate also is a content-based regulation under traditional First Amendment law and for purposes of plaintiffs' Section 11 claims. The Reason Mandate targets the "communicative content" of the physician-patient meeting

by requiring abortion providers, including the Provider plaintiffs, to affirmatively inquire of their patients seeking an abortion:

- Which of a State-mandated and preconceived specified list of eleven "reasons" is the patient's "most important reason" for seeking to terminate their pregnancy. Many of these listed reasons are emotive (rape, incest, fetal abnormality/disability, etc.), reflect derogatory or pejorative connotations (patient has "too many" children), destroy or undermine the physician patient relationship/patients' trust, and are potentially stigmatizing/traumatizing;
- Whether the patient has received, during the 30 days prior to the abortion, "services, financial assistance . . . , or other assistance" form a nonprofit organization that supports pregnant women;
- Whether the patient reported having experienced domestic violence within the 12 months prior to the abortion; and
- Whether the patient is living in a place that she considers "safe, stable, and affordable."

FOF, ¶¶ 39-47. All of these inquiries must be asked ***prior to receiving an abortion***. The Reason Mandate permits, as previously discussed, a patient to decline to answer the "most important reason" question, which the provider must then document. However, the provider must ask, in some form, and patients must nonetheless review and consider the entirety of the questioning and affirmatively indicate they do not wish to respond. There is no ability of a patient to decline or opt out of any other questioning required by the Reason Mandate, and the physician provider has no ability to decline to engage in any of the required inquiries, regardless of their own professional medical judgment as to the propriety of the inquiry for a given patient. Compare *Casey*, supra (Pennsylvania statute that afforded abortion providers the discretion to refrain from required disclosures, where they reasonably believed the inquiry would have a serious adverse effect on the patient).

Again, the trial evidence clearly reflects that the Reason Mandate undoubtedly alters the content of the physician providers' speech, as it relates to the normal informed consent discussions prior to an abortion, and compels them, irrespective of their medical judgment and professional standards, to engage in state-mandated speech and questioning that is, in their view, unnecessary, unhelpful, and often harmful and stigmatizing discussions with their patients. See FOF, ¶¶ 272-284. Notably, the Provider plaintiffs' witnesses all testified that the questions were largely medically-irrelevant and harmful and that they would not ask those types of questions, absent some statutory mandate. See FOF, ¶ 272. The Reason Mandate is also textbook "content based" regulation on this subject.

Given that these Subject Laws are, at least, content based statutory schemes[68] and that they alter the nature of the Provider plaintiffs' speech, this Court will apply the strict scrutiny standard, as it is obligated to do.

c. In light of the evidence in the record, the Subject Laws fail strict-scrutiny review. The State Defendants have failed to demonstrate that the Subject Laws are narrowly tailored to further, in fact, a compelling governmental interest aimed at a real problem.

Having concluded that the WRTKA (including the APR Mandate supplementing it) are content-based regulatory schemes and merit strict-scrutiny review, the analysis becomes relatively straightforward.

[68] There are compelling (and likely meritorious) arguments, in this Court's view, that the Subject Laws are, in fact, also viewpoint discriminatory, which would require even more skepticism by the Court of the Government's conduct. See note 58, supra.

To survive strict scrutiny, for Section 11 purposes, the State must demonstrate that the Subject Laws (which are presumptively-unconstitutional content-based laws) are:

1. Enacted to advance a compelling governmental interest; and
2. Advances, in fact, the stated interest, in a narrowly-tailored fashion, using the least restrictive means.

See *Chiles*, supra at 1021; see also *Reed v Town of Gilbert*, supra at 155. Under such a test, it is "rare that a regulation . . . . will ever be permissible." *Chiles*, supra at 1021 (citation omitted).

The State Defendants have not adequately demonstrated that the WRTKA was enacted to further a compelling governmental interest; nor have they demonstrated that it, in fact, advances such a compelling interest in a narrowly-tailored way. The Act (along with its APR Mandate, as a supplement) are presumptively unconstitutional, given their content-based nature, and the State's sole asserted interest and justification, vis-à-vis Section 11 of the Kansas Constitution's Bill of Rights, appears to be "upholding the integrity" of the medical community through "professional regulation." However, the record is devoid of credible evidence to support that such an interest is truly "compelling"--or even important or legitimate.[69] It is merely hypothetical, on this record,

[69] As mentioned previously, the State Defendants have put forth several generalized and hypothetical "interests," in a less-than-specific manner, in order to attempt to justify the various schemes at issue. This lack of clarity and transparency tends to undermine the State Defendants' position and leaves the Court to often speculate as to what interest(s) they sincerely argue are furthered by the each of the Subject Laws. To the extent that the State Defendants are asserting some other governmental interest to support their defense on plaintiffs' Section 11 claims (for example, maternal health, respect for potential life, or "enhancement of autonomy"), the Court finds such interests as uncompelling as it found them for purposes of a Section 1 analysis relating to the right to bodily autonomy by plaintiffs' patients. Rather than restate the reasons why they are not "compelling" or even "important" or "legitimate," the Court will incorporate its earlier conclusions and discussion by reference herein. See discussion Section IV.B.5.a, supra.

much like California's asserted interest in the laws described in *NIFLA*. See *NIFLA*, supra at 2377 ("California has not demonstrated any justification for the unlicensed notice that is more than 'purely hypothetical.'"). Indeed, the State Defendants openly concede the lack of any prior disciplinary issues, including on informed consent matters, with Provider plaintiffs or any other relevant group. See Pretrial Order, Index No. 630 pg. 26. Absent evidence demonstrating an *actual* compelling justification/interest underlying the WRTKA, the Act fails strict scrutiny review.

Further, even if there was a non-hypothetical compelling justification for the WRTKA, the Act substantially burdens protected speech and is not narrowly tailored to effectuate the purported justification. It, much like the laws in *NIFLA*,[70] imposes a State-mandated, scripted, and speaker-based disclosure that effectively replaces any meaningful level of discretion, autonomy, or judgment by the Provider plaintiffs and by others similarly impacted. And it conscripts those providers to eschew their own professional opinions and judgment, in the interest of simply parroting the State's

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[70] The *NIFLA* Court particularly stressed "the danger of content-based regulations "in the fields of medicine and public health, where information can save lives." *NIFLA*, supra at 2374 (citing *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 566, 131 S.Ct. 2653, 180 L.Ed.2d 544 (2011)). The majority highlighted:

> "The dangers associated with content-based regulations of speech are also present in the context of professional speech. ***As with other kinds of speech, regulating the content of professionals' speech "pose[s] the inherent risk that the Government seeks not to advance a legitimate regulatory goal, but to suppress unpopular ideas or information.***" *Turner Broadcasting*, 512 U.S., at 641, 114 S.Ct. 2445. **Take medicine, for example. "*Doctors help patients make deeply personal decisions, and their candor is crucial.*"** *Wollschlaeger v. Governor of Florida*, 848 F.3d 1293, 1328 (C.A.11 2017) (en banc) (W. Pryor, J. concurring). ***Throughout history, governments have "manipulat[ed] the content of doctor-patient discourse" to increase state power and suppress minorities***"

NIFLA, supra at 2374 (emphasis added). Those sentiments are equally applicable here, where the State Defendants seek to subvert the exercise of medical judgment in conformity with the professional standard of care through a "laundry list" of content-specific and largely medically-irrelevant disclosures that are aimed at influencing the patient's choice to conform with the State's preference—not properly informing it on reasonable risks, benefits, and alternatives discussions that are patient-tailored.

chosen messages—no matter the circumstances or specifics of an individual patient's desires, needs, or decisional certainty or of the providers' own independent desired messaging, given the prevailing professional standard of care.[71] Curiously, it targets a very discreet and specialized subset of healthcare providers for unique treatment, as speakers, for only this particular type of healthcare. In doing so, the WRTKA (including the APR Mandate) chills and directly undermines the Provider plaintiffs' (and others similarly situated) Constitutionally-protected speech.

The WRTKA doesn't seek to accomplish its purported motivating interest(s) in any narrow sort of way. Indeed, if there were a compelling and demonstrable need to regulate the profession broadly, to "uphold the integrity of the medical profession" by allegedly ensuring valid informed consent, one more narrow manner might be to simply require "written confirmation of informed consent" by a patient *for all procedures*—without dictating the specifically-mandated substance and without limiting the regulatory effort to a particular and small subset of providers (obstetricians that provide abortions in Kansas).[72] Instead, the WRTKA (including the APR Mandate) takes an incredibly overbearing and specific approach to "regulating" this small and disfavored group, and only as to a specific procedure. In that regard, it is simply not the type of "narrowly tailored" effort to further and uphold the "integrity of the profession," as required by free-

[71] These provisions of the WRTKA, including the APR Mandate, are a systematic and exhaustive effort by the State to wedge itself into the confidential physician-patient relationship and to supplant the professional's expert medical judgment for those views and positions it prefers. In that respect, it is more akin to "inundated consent" that impairs the decision-making process than "informed consent". See *NIFLA*, supra, pg. 2378 (discussing how, with respect to at least the unlicensed notice, detailed disclosure requirements that are inconsistent with the speaker's intended speech can "drown out" the speaker's own message).

[72] Indeed, the WRTKA requirements are distinctly different from the broader administrative and statutory provisions that reference "informed consent" to which the State Defendant point, with respect to regulating "informed consent." See discussion section IV.B.5., n 49, supra.

speech precedent for content-based laws, even if there were credible evidence in the record that this interest reflected an *actual compelling problem* to be addressed at the time of passage. Thus, it cannot withstand constitutional scrutiny, as required by Section 11 of the Kansas Constitution's Bill of Rights, given the evidence mustered by the State Defendants.

Similarly, the Reason Mandate, which is equally content based, fails essentially any level of scrutiny, but certainly falls significantly short of satisfying strict scrutiny, in the Court's view. Again, the State Defendants summarily indicate that the Reason Mandate is merely "the State asking voluntary questions." (Trial Tr. vol. VII (PM) 105: 7-9 (Nussbaum)) It is not, and it doesn't even constitute valid "public health surveillance," as described in the evidence, because it has no *a priori* purpose. Dr. Lee's testimony on these points was extremely compelling, and her credentials and qualifications were strong and largely authoritative on such issues. See FOF,¶¶ 78, 95 n.7, 243-56. Indeed, the Court is hard pressed, *on this record*, to even articulate a *hypothetical* purpose or interest that justifies the Reason Mandate. This conclusion is stark and unavoidable, particularly given that the KDHE (who presumably is responsible for maintaining, analyzing, and utilizing this "public health" data) was not consulted as to the need for or utility of the data that would be collected. FOF, ¶ 46. Absent a demonstrable non-hypothetical "compelling" interest, the State Defendants cannot satisfy their burden of proof. See *NIFLA*, supra at 2377-78.

And even if there were some nebulous and as-of-yet unarticulated interest that legitimately existed;[73] that precipitated the Reason Mandate; and that was either important or compelling, the Act would nonetheless fail strict scrutiny because it doesn't further a purported interest in any sufficiently-tailored fashion. Indeed, it is wildly underinclusive. If Kansas' goal and "interest" was to improve "public health" data on pregnant women and assist pregnant women (as could be possibly extrapolated from legislator's statements) to carry a pregnancy through delivery and childbirth, the Reason Mandate leaves swaths of other healthcare providers that treat pregnant women for either prenatal care or care unrelated to their pregnancy unbridled with any similar obligation/mandatory inquiry regarding domestic violence, secure living environment, and/or financial aid received. And this law also simply overlooks all pregnant women that 1) haven't made a concrete decision on whether to continue their pregnancy; 2) that have affirmatively decided to proceed to anticipated delivery; or 3) that are seeking non-pregnancy related care. Instead, the law only requires the mandated interrogations when the pregnant women wish to terminate their pregnancies. So, no information on any other subset of pregnant women or regarding what was the "most important" reason for their choice or care plan is contemplated or would be collected under the law. In that respect, it is simply under-inclusive.

This Court must express deep skepticism of laws that "distinguis[h] amongst different speakers, allowing speech by some but not others." See *NIFLA*, supra at 2378 (citing *Citizens United v. FEC,* 558 U.S. 310, 340, 130 S.Ct. 876 (2010)). This same

[73] Other than the grossly inadequate justification proffered through the statements from a state legislator and sponsor that the Act was intended to: ""[m]ake sure ***we're making the right decision for*** these women," who are seeking abortions in Kansas. Pls.' Ex. 11 (House Journal, p. 3420 (Apr. 29, 2024)) (emphasis added).

principle must hold true where the regulatory efforts similarly **require** certain state-preferred speech/inquiry by a small and discrete group—but not others. Indeed, such "[u]nderinclusiveness raises serious doubts about whether the government is in fact pursuing the interest it invokes, rather than disfavoring a particular speaker or viewpoint." *NIFLA*, supra at 2376. Given the record, the Court's required skepticism has matured into conviction that the Reason Mandate simply seeks to unlawfully harness this small group of providers and commandeer them to act as the State's foot soldiers in the State's "voluntary" questioning. In short, the Reason Mandate also fails to pass constitutional muster because it infringes upon the Provider plaintiffs' fundamental right to free speech, as guaranteed by Section 11 of the Kansas Constitution's Bill of Rights. The State Defendants have wholly failed to articulate and prove a compelling governmental interest that is advanced by the law in a narrowly-tailored fashion.

D. The Subject Laws Violate pregnant women's rights to Equal Protection enshrined in Section 2 of the Kansas Constitution's Bill of Rights.

The Provider plaintiffs have also challenged the Subject Laws on the grounds that those laws violate the right to equal protection under law, which is guaranteed to their patients by Section 2 of the Kansas Constitution's Bill of Rights. Plaintiffs argue that the laws discriminate because of sex/gender, resulting in disparate treatment of equivalent groups, and because they infringe upon the fundamental rights of their patients. The State Defendants counter that these laws are legitimate exercises of the State's traditional "police power" and are permissible under a deferential rational-basis review. The Court, having carefully considered the issues, concludes that the Subject Laws violate the equal-protection rights enshrined in Section 2 because they infringe

upon pregnant women's fundamental rights to bodily autonomy, as it relates to their decision to terminate or continue with their pregnancy.

The right to equal protection of the law is grounded in Section 2 of the Kansas Constitution Bill of Rights, which states:

> "All political power is inherent in the people, and all free governments are founded on their authority, and are instituted for their equal protection and benefit. No special privileges or immunities shall ever be granted by the legislature, which may not be altered, revoked or repealed by the same body; and this power shall be exercised by no other tribunal or agency."

Kan. Const. Bill of Rights, § 2; see also *Rivera v. Schwab*, 315 Kan. 877, 894, 512 P.3d 168, 180 (2022).[74]

A general premise underpinning EPC analysis is that the equal protection clause does not categorically prevent the government from making classifications. *Eisenstadt v. Baird*, 405 U.S. 438, 446-47, 92 S. Ct. 1029, 31 L. Ed. 2d 349 (1972). Rather, it requires that governmental classifications are not intentionally discriminatory. *Id.* States may not "legislate that different treatment be accorded to persons placed by a statute into different classes on the basis of criteria wholly unrelated to the objective of the statute." *Reed v. Reed*, 404 U.S. 71, 75-6, 92 S. Ct. 251, 30 L. Ed. 2d 225 (1971).

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[74] Kansas equal protection jurisprudence ("EPC") traditionally interpreted Sections 1 and 2 of the Kansas Constitution Bill of Rights in alignment with the due process and equal protection guarantees found in the Fourteenth Amendment to the U.S. Constitution. *Rivera v. Schwab*, 315 Kan. 877, 891, 512 P.3d 168, 180-1 (2022) (referencing *Farley v. Engelken*, 241 Kan. 663, 667, 740 P.2d 1058 (1987) (Sections 1 and 2 of the Kansas Constitution Bill of Rights "are given much the same effect as the clauses of the Fourteenth Amendment [of the U.S. Constitution] relating to due process and equal protection of the law."). However, *Rivera* clarified that it is actually Section 2—not Section 1—that is relevant for equal protection purposes in Kansas under the state Constitution. *Rivera*, supra at 894 (referencing the distinction made between Section 1 and Section 2 as a result of *Hodes I*). Regardless, the guarantees in the Kansas equal protection clause are coextensive with those found in the Fourteenth Amendment to the United States constitution. *Id.* at 894. Thus, federal precedent interpreting the Due Process clause of the Fifth Amendment to the US Constitution (and, applicable to the states via the Fourteenth Amendment to the US Constitution) are instructive and persuasive authority.

Classifications must be "reasonable, not arbitrary, and must rest on some ground of difference having a fair and substantial relation to the object of the legislation, so that all persons similarly circumstanced be treated alike." *Id.* (citation omitted).

Kansas courts analyzing EPC claims utilize a "stair-step" approach. First, the court determines whether the legislature creates a classification resulting in different treatment of similarly situated individuals. See *In re Weisgerber*, 285, Kan. 98, 104, 169 P.3d 321 (2007) (a challenger "seeking to establish an equal protection violation must demonstrate that his or her treatment is the result of a deliberately adopted system which results in intentional systematic unequal treatment"). If the court finds that the legislation does treat similarly situated individuals differently, the court next examines the nature of the rights implicated by the classification, and then, the court must apply the appropriate level of scrutiny for those rights.[75] *Miami Cnty. Bd. of Comm'rs v. Kanza Rail-Trails Conservancy, Inc.*, 292 Kan. 285, 315 255 P.3d 1186, 1207 (2011); *State v. Limon*, 280 Kan. 275, 283, 122 P.3d 22, 28 (2005).

As a general rule, laws are subject to rational basis review, unless the classification targets a suspect class or burdens a fundamental right. *Romer v. Evans*, 517 U.S. 620, 631, 116 S. Ct. 1620, 1628, 134 L. Ed. 2d 855 (1996). In Kansas, EPC challenges based on gender require intermediate scrutiny, whereas EPC challenges based on violations of fundamental rights trigger strict scrutiny. See *In re K.M.H.*, 285

[75] Whether evaluated at a state or federal level, equal protection under law is guaranteed by reviewing the relevant governmental action against three distinct and well-recognized standards—rational basis, intermediate scrutiny, and strict scrutiny. The level of scrutiny will largely depend upon the nature of the rights implicated and the classifications made by the State. *See Miami Cnty. Bd. of Comm'rs v. Kanza Rail-Trails Conservancy, Inc.*, supra at 315.

Kan. 53, 73 169 P.3d 1025, 1039 (2007) (gender-based equal protection claims subject to "intermediate" scrutiny); c.f, *Juardo v. Popejoy Const. Co.*, 253 Kan 116, 124, 853, P.2d 669, 675-6 (1993) (equal protection claims based upon violation of fundamental rights are governed by strict scrutiny).

In this case, the Provider plaintiffs allege that the Subject Laws run afoul of equal-protection concerns because they:

> "discriminate based on how pregnant people exercise their fundamental right to personal autonomy; and
>
> discriminate against abortion patients based upon sex. . . ."

See Pretrial Order, Index No. 630, pg. 5-6 (subparagraphs d, e).

The Court will accept the plaintiffs' framing and distinctions raised, in order to address their EPC claims. See *State v. Salas*, 289 Kan 245, 249, 210 P.3d 635, 639 (2009) ("the parameters of a courts consideration of whether individuals are similarly situated is set by the distinctions argued by the complaining party."); see also *State v. Little*, 58 Kan.App.2d 278, 280, 469 P.3d 79, 81 (2020) (the party brining the claim "gets to define the groups being compared for differing treatment.").

The Court concludes that plaintiffs have demonstrated that their patients are, in fact, subject to disparate treatment by the Subject Laws when compared to other similarly-situated individuals (other pregnant women making reproductive health choices or others making any other reproductive health decisions).[76] As discussed at great

[76] Similar to the Court's prior observations, the State Defendants' largely-generalized and scattershot approach to articulating the purported lawful governmental interest/purpose renders this Court's job more difficult when attempting to place the Subject Laws in the proper context with respect to a particular interest. In the EPC context, the Court has presumed that the State Defendants contend that the interests of: "enhanced autonomy," "maternal health," "respect for potential life," and "upholding the integrity of the medical profession" are the relevant interests, just as it did for the Section 1 and 11 claims.

length above, the Subject Laws single out and target pregnant women contemplating the termination of their pregnancy early in the process (prior to 22 weeks LMP). See discussion Section IV.B, supra. The Subject Laws inundate these pregnant women with lengthy, redundant, stigmatizing, and often inaccurate/misleading information or questioning, along with corresponding delays of the care they seek, based solely upon their posture of seeking care to terminate their pregnancy. *Id.* Conversely, other pregnant women that are not seeking care related to termination of their pregnancy and, instead, seek care related to continuing their pregnancies (or those that seek any other reproductive care, whether men or women), are not subjected to any of the requirements imposed by the Subject Laws—either the voluminous disclosure requirements of the WRTKA, the mandatory delays, or the stigmatizing questioning mandated by the Reason Mandate . On their face, the Subject Laws intentionally differentiate between similar groups of individuals. Thus, the question next becomes: what is the nature of the rights implicated?

As also detailed above in Section IV.B., the rights implicated in the Subject Laws are pregnant women's right to exercise bodily autonomy, which is guaranteed by Section 1 of the Kansas Constitution's Bill of Rights. And because that right has been found to be fundamental, strict scrutiny must be applied to the laws. See *Hodes I*, supra; *Hodes II*, supra; *Hodes III*, supra.

This Court has already concluded that the Subject Laws fail strict scrutiny under a Section 1 analysis, and thus, they violate pregnant women's fundamental rights. See

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The Court's conclusion (that the Subject Laws differentiate between similarly-situated groups) flows from this review of interests, even though the Court concludes that none of these are demonstrably compelling, and several are not even clearly important or legitimate *in this case*, as it relates to these Subject Laws.

discussion Section IV.B., supra. The analysis, for equal protection purposes, is no different and demands the same result. Just as in the Section 1 context, the State Defendants have simply failed to sufficiently prove that their regulatory schemes were motivated by a compelling governmental interest and that it, not just in theory but in fact, advances that interest in a narrowly tailored fashion. See discussion Section IV.B. Rather than restating that analysis again, the Court adopts and incorporates those findings and conclusions herein by reference. And since the Subject Laws fail strict-scrutiny and infringe upon the fundament rights of this distinct group of pregnant women, they cannot pass constitutional scrutiny from an equal protection standpoint either.

In light of the Court's conclusion that the Subject Laws violate the rights of pregnant women, including plaintiffs' patients, to equal protection by impairing and infringing upon their fundamental natural rights, the Court concludes it is unnecessary to further analyze and determine whether the Subject Laws *alternatively* constitute discrimination on the basis of sex, from an equal protection standpoint. Such an analysis would be potentially duplicative and unnecessary, given the Court's ruling herein. Thus, it declines to further address the plaintiffs' alternative claim for equal protection violations.

E. Are the provisions of the APR Mandate void for vagueness?

The Provider plaintiffs contend that the APR Mandate must also be invalidated because it is "void for vagueness." See Pretrial Order, pg. 6 (subparagraph g). They contend that it does not provide "fair warning" regarding the meaning of the following statutory language:

> "other relevant telephone or internet resources containing information on where the patient can obtain timely assistance to attempt to reverse the medication abortion."

K.S.A. 65-6716 (2025) (formerly H.B. 2264).[77] The State Defendants deny that the provision is unconstitutionally vague.[78] See Pretrial Order, pg. 7 (subparagraph i).

The "void for vagueness" is a doctrine rooted in the Fifth and Fourteenth Amendment's Due Process clauses. This doctrine essentially requires the government to "fairly appraise persons of what actions will result in a loss of liberty or loss of property, so that those persons may conduct themselves" accordingly. *Banks v. Spirit Aerosystems Inc.*, 457 P.3d 213 (Kan. Ct. App. 2020).

A statute can be impermissibly vague in two ways. First, it is impermissibly vague if it fails to provide people of ordinary intelligence a reasonable opportunity to understand what conduct it requires; alternatively, a statute is impermissibly vague if it authorizes or encourages arbitrary and discriminatory enforcement. *Spiehs v. Armbrister*, No. 24-4005-JAR-BGS, 2025 WL 548423 (D. Kan. Feb. 19, 2025). In other words, the test is whether the law/regulation at issue gives fair warning to those potentially subject to it and whether the law adequately guards against arbitrary and

[77] This language appears both in the "conspicuous" sign requirement of K.S.A. 65-6717(b)(1) and in the written disclosure requirement of subsection (c)(1)(B).

[78] Unfortunately, the State Defendants have simply failed at trial to articulate or demonstrate why the statute is not unconstitutionally vague or addressed the issue at all, outside of conclusory statements. See PTO, pg. 7; 53. Thus, the Court is left to simply analyze the issues without reasonable guidance from the State on its view and analysis. This same shortcoming can also be said for the issue of severability of the statutory provisions, as the State Defendants essentially provide nothing more than conclusions and summary black-letter case law.

discriminatory enforcement. *State v. Lackey*, 232 Kan. 478, 480, 657 P.2d 40, 41-2 (1983).

The Court concludes that the Provider plaintiffs have failed to meet their burden to demonstrate that the APR Mandate is impermissibly vague. In a vacuum, the language might appear to leave broad latitude to the State to determine what "other relevant" resources are and whether individual providers are in compliance. Undoubtedly, one could argue that the Law is susceptible to ambiguity and potentially to arbitrary enforcement. However, when read in its entirety, the APR Mandate is sufficiently clear that, if it were ever implemented,[79] those subject to the law could reasonably understand what conduct it requires. Thus, it is not unconstitutionally vague.

Notably, K.S.A. 65-6716 not only has the provider obligation, with respect to notification/disclosure to patients, but it also mandates that KDHE:

> "shall cause to be published, in English and in each language that is the primary language of 2% or more of the state's population, in print and on the website required to be maintained under K.S.A. 65-6710, and amendments thereto, comprehensible materials designed to inform women of the possibility of reversing the effects of a medication abortion that uses mifepristone and information on resources available to reverse the effects of a medication abortion that uses mifepristone. **The website shall also include <u>other relevant telephone and internet resources containing information on where the patient can obtain timely assistance to attempt to reverse the medication abortion</u>.**"

[79] The Court notes that it has already invalidated this law herein on other grounds (infringes upon bodily autonomy), as it violates the fundamental rights of plaintiffs and their patients that seek abortions, so this discussion is largely academic.

K.S.A. 65-6716(g) (2025) (emphasis added). This language exactly mirrors what a physician provider must also provide, in writing and in "conspicuous" signage, to patients under the law. See K.S.A. 65-6716(c)(1)(B) (2025).

Given the interplay between these two provisions, the Court concludes that the APR Mandate, when read as a whole, provides reasonable notice to providers as to what is expected of them. While there certainly could be some potential for arbitrary and/or discriminatory enforcement, this Court will not assume that such arbitrary enforcement is likely. Instead, this law, which has never been in effect and is permanently enjoined herein, appears reasonably clear in terms of what a physician must provide. The reasonable reading of these provisions, when read in context, is that the providers must provide substantively the same information as that contained on the KDHE website, once the agency determined what those "other relevant . . . . resources" are. It requires no more and no less. Indeed, the Court is hard pressed to see how the State Defendants could consider it a violation of the APR Mandate for a provider to omit resources that the State's leading public health agency did not likewise consider "relevant" to the statute's requirements. Mirroring the KDHE website data would appear compliant. While that website content/information is not yet known,[80] based upon the record, the statutory language is not, in this Court's view, void for "vagueness" under Kansas law. The Court rejects plaintiffs' claim in that regard.

[80] And it is entirely speculative, given this case's posture and decision set forth herein.

F. Facial constitutional challenges in Kansas and the applicability of *Salerno's "no set of circumstances" language.*

Having analyzed plaintiffs' various claims under the relevant and established constitutional frameworks, the Court will address one final issue raised by the State Defendants. Specifically, the Court turns to their contention that mounting a successful facial challenge to the Subject Laws requires the plaintiffs to demonstrate that there are "no set of circumstances" under which the Subject Laws can be constitutionally applied. See Pretrial Order, Index 630; pg. 46-47.

This proposition and concept appears derived from a United States Supreme Court case, *United States v. Salerno*, 481 U.S. 739, 745, 107 S.Ct. 2095, 95 L.Ed.2d 697 (1987). In *Salerno*, Chief Justice Rehnquist opined (in dictum) that:

> [a] facial challenge is, of course, the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the Act would be valid. The fact that the Bail Reform Act might operate unconstitutionally under some conceivable set of circumstances is insufficient to render it wholly invalid, since we have not recognized an 'overbreadth' doctrine outside the limited context of the First Amendment.

Id. at 745.

Thereafter, that "no set of circumstances" language precipitated a confusing and often-inconsistent body of decisions and comment from the United States Supreme Court, various lower federal courts, and numerous state courts regarding its applicability and/or relationship with existing standards of constitutional review. See *e.g.*, *City of Chicago v. Morales,* 527 U.S. 41, 55 n. 22, 119 S.Ct. 1849, 144 L.Ed.2d 67 (1999) (plurality opinion) ("[t]o the extent we have consistently articulated a clear standard for facial challenges, it is not the *Salerno* formulation, which has never been the decisive factor in any decision of this Court, including *Salerno* itself."); *Washington v. Glucksberg*,

521 U.S. 702, 739–40, 117 S.Ct. 2258, 138 L.Ed.2d 772 (1997) (Stevens, J., concurring) (criticizing the strictness of *Salerno* and noting the debate over the appropriate standard); *Janklow v. Planned Parenthood, Sioux Falls Clinic*, 517 U.S. 1174, 1175, 116 S.Ct. 1582, 134 L.Ed.2d 679 (1996) (Stevens, J., respecting denial of cert.) ("*Salerno*'s rigid and unwise dictum has been properly ignored in subsequent cases even outside the abortion context."); see also *Doe v City of Albuquerque*, 667 F.3d 1111 (10th Cir. 2012) (summarizing the inconsistent opinions and concluding "[t]he idea that the Supreme Court applies the "no set of circumstances" test to every facial challenge is simply a fiction.").

Indeed, the US Supreme Court has consistently engaged in facial challenges not through the specific lens of "no set of circumstances" but by applying the relevant constitutional test for the laws implicated. See *Doe v. City of Albuquerque*, supra at 1124 (gathering numerous cases from the various circuit courts of appeal that have eschewed the *Salerno* language and utilized the traditional constitutional tests); see also *Brown v. Entm't Merchs. Ass'n,* 564 U.S. 786, 131 S.Ct. 2729, 2738, 2742, 180 L.Ed.2d 708 (2011) (applying strict scrutiny in concluding that statute prohibiting the sale or rental of "violent video games" to minors violated the First Amendment); *Nat'l Endowment for the Arts v. Finley*, 524 U.S. 569, 572–73, 585, 118 S.Ct. 2168, 141 L.Ed.2d 500 (1998) (noting that even though statute providing for NEA funding could be constitutionally applied in certain situations, "these permissible applications would not alone be sufficient to sustain the statute against respondents' First Amendment challenge,"—thereby directly contradicting the "no set of circumstances" test); *Planned Parenthood v. Casey*, 505 U.S. 833, 869–901, 112 S.Ct. 2791, 120 L.Ed.2d 674 (1992)

(upholding certain provisions of a Pennsylvania abortion statute and striking down the spousal-notification provision without applying *Salerno*).

Federal circuit courts and numerous notable scholarly commentators have also roundly criticized this dictum and rejected it as an actual constitutional test or standard. See *Doe v. City of Albuquerque*, supra at 1123-27 (compiling cases rejecting, criticizing, and/or questioning the applicability of a "*Salerno* test" and explaining import of the language); Marc E. Isserles, *Overcoming Overbreadth: Facial Challenges and the Valid Rule Requirement*, 48 Am. U.L.Rev. 359, 387 (1998) ("*Salerno*'s 'no set of circumstances' is not a 'test' that prescribes an application-specific method of determining constitutional invalidity, but rather a descriptive claim about a statute whose terms state an invalid rule of law."); Richard H. Fallon, Jr., *Facial Challenges, Saving Constructions, and Statutory Severability*, 99 Tex. L. Rev. 215, 228 (2020) ("[]he widespread availability of facial challenges flows from judicially prescribed tests of constitutional validity that dominate modern constitutional law"). Indeed, the Tenth Circuit has consistently concluded:

> "*Salerno*'s language thus is accurately understood **not as setting forth a test for facial challenges, but rather as describing the result of a facial challenge in which a statute fails to satisfy the appropriate constitutional standard.** In other words, ***where a statute fails the relevant constitutional test (such as strict scrutiny, the Ward test, or reasonableness review), it can no longer be constitutionally applied to anyone—and thus there is "no set of circumstances" in which the statute would be valid.*** **The relevant constitutional test, however, remains the proper inquiry**."

Doe, supra at 1127; see also *United States v. Supreme Court of New Mexico*, 839 F.3d 888, 917 (10th Cir. 2016) ("Even so, we have construed *Salerno*'s no-set-of-circumstances language "not as setting forth a test for facial challenges, but rather as

describing the result of a facial challenge in which a statute fails to satisfy the appropriate constitutional standard.'") (citing *Doe*).

As a result, the majority of federal circuit courts adopt this view. See *Montana Medical Association v. Knudsen*, 119 F.4th 618, 631-34 (9th Cir. 2024) (McKeown, concurring) (citing *Doe* and opining that *Salerno* does not set forth a relevant test/standard but rather an outcome, as well as noting that "[t]he majority of the circuits simply apply the relevant constitutional test in preemption cases—whether facial or as-applied."); *Club Madonna Inc. v. City of Miami Beach*, 42 F.4th 1231, 1256 (11th Cir. 2022) (citing *Doe* and framing the *Salerno* language as "requir[ing] us to answer is whether the statute fails the relevant constitutional test"); *Bruni v. City of Pittsburgh*, 824 F.3d 353, 362-63 (3rd Cir. 2016) (rejecting the application of a "*Salerno* test" and noting "[t]he [US Supreme] Court has often considered facial challenges simply by applying the relevant constitutional test to the challenged statute, without trying to dream up whether or not there exists some hypothetical situation in which application of the statute might be valid").

For their part, the Kansas appellate courts have referenced *Salerno* and periodically used the "no set of circumstances" language, but its application remains uncertain, at least in the context of this case. The Kansas cases discussing or applying the "no set of circumstances" language as a "test" in any detail deal specifically with ***rational basis review of equal protection claims***. In that context, the Kansas appellate courts consistently hold:

> "***Where, as in this case, a party attacks a statute as facially unconstitutional under the Equal Protection Clause for failing to satisfy the rational basis standard, the party must demonstrate that***

> ***'no set of circumstances exist' that survive constitutional muster.*** For this reason, it is not enough to '[s]imply point[ ] out that [a statute] might not be rationally related to the state objectives sought under one set of facts.' Instead, ***a party 'asserting the unconstitutionality of a statute under the rational basis standard "ha[s] the burden 'to negative every conceivable basis which might support [the classification].'*** " ' [Citations omitted.]"

Board of Miami County Comm'rs v. Kanza Rail–Trails Conservancy, Inc., 292 Kan. 285, 315–16, 255 P.3d 1186 (2011) (emphasis added); see also *Miller v. Johnson*, 295 Kan. 636, 668, 289 P.3d 1098, 1120 (2012);*Villa v. St. Kansas Health Policy Auth*., 296 Kan. 315, 324, 291 P.3d 1056, 1065 (2013); *Downtown Bar and Grill, LLC v. State*, 294 Kan. 188, 195 (2012) (same); *Hodges v. Johnson*; 288 Kan. 56, 73, 199 P.3d 1251, 1264 (2009); *Injured Workers of Kansas v. Franklin*; *In re Weisgerber*262 Kan. 840, 850-51, 942 P.2d 591 (1997); *Bullard v. Kansas Dept. of Rev*., 349 P.3d 491, 2015 WL 3514030, at *14 (Kan. Ct. App. 2015) (citing *Hodges*) (unpublished); *Hall v. Kansas Dept. of Rev*., 298 P.3d 1138, 2013 WL 1688887 (Kan. Ct. App. 2013) (citing *Kanza Rail*) (unpublished).

The "no set of circumstances" language has also appeared in appellate decisions addressing "void for vagueness" facial challenges in Kansas. See *State v. Valdiviezo-Martinez*, 313 Kan. 614, 631, 486 P.3d 1256, 1267 (2021) (citing *In re Weisgerber*, 285 Kan. 98, 105, 169 P.3d 321 (2007); *State v. Watson*, 273 Kan. 426, 435, 44 P.3d 357, 364 (2002) (applying void for vagueness rules before mentioning "no set of circumstances" in passing).

However, references by our appellate courts to the "no set of circumstances" language as some type of concrete test have been expressly limited to circumstances where the law at issue ***does not*** *facially* limit constitutionally-protected conduct or does

not disparately treat similarly-situated individuals. See *Valdiviezo-Martinez*, supra at 631-32 (citing *Hearn v. Overland Park*, 244 Kan. 638, 641, 772 P.2d 758 (1989) for the proposition that "[i]f a law does not limit constitutionally protected conduct, it should be upheld unless it is impermissibly vague in all its applications."). As such, the laws at issue possessed a constitutional presumption of validity, and the cases were ultimately analyzed by application of the requisite framework for constitutional scrutiny,[81] not by any comprehensive analysis of hypothetical and abstract circumstances where the statute *might* be constitutionally applied. See *e.g.*, *State v. Ryce*, supra at 915-16, 931 (declining to consider "the entire universe of possible, theoretical circumstances" as part of its facial challenge review). Indeed, the Kansas Supreme Court has observed that the proper focus for facial unconstitutionality is "the group for which the law is a restriction, not the group for whom the law is irrelevant." See *Id.* at 915-16 (2016) (citing *Los Angeles v. Patel*, 576 U.S. 409, 418, 135 S.Ct. 2443, 12451, 92 L.Ed.2d 435 (2016) and quoting *Planned Parenthood of S.E. Pa. v. Casey*, 505 U.S. 833, 894, 112 S.Ct. 2791, 120 L.Ed.2d 674 (1992)).

In contrast, Kansas appellate courts have ***not*** typically utilized this "no set of circumstances" language as an articulated test or uniquely-defined standard when analyzing infringement of fundamental rights claims. Instead, those Kansas decisions addressing fundamental-rights claims have largely turned on the application of the requisite level of scrutiny, much like the Tenth Circuits approach. From that standpoint, Kansas courts approach in such situations appears to coincide with the majority of

[81] Notably, the standards for such equal protection (using rational basis review) and void for vagueness challenges, where constitutionality is presumed, are considerably lower than those required here for Plaintiffs' claims. Thus, the "no set of circumstances" language and characterizations of such challenges as "the most difficult" appear more analytically apt where there remains a presumption of constitutionality.

federal circuits addressing *Salerno*'s significance. See *Hodes I*, supra at 663-498 (adopting strict scrutiny as standard of review for infringements on natural rights like personal autonomy); *Hodes II*, supra at 1015-33 (applying strict scrutiny without mention of *Salerno* or the "no set of circumstances" language); *Hodes III*, supra at 950-51 (same); *State v. Jones*, 313 Kan. 917, 931-32, 492 P.3d 433, 445-46 (2021) (First Amendment/free speech "overbreadth" challenge analyzed using two part test to evaluate constitutionality, rather than "no set of circumstances"); *State v. McCray*, 321 Kan. 316, 320, 576 P.3d 126, 129-130 (2025) (Second Amendment challenge); *State v. Watson*, 273 Kan. 426, 44 P.3d 357 (2002) (void for vagueness challenge and applying requisite constitutional test and characterizing outcome using "no set of circumstances" language as the outcome); See *Doe v. City of Albuquerque*, 667 F.3d 1111,1123-27 (10th Cir. 2012),(collecting cases clarifying the use and role of the *Salerno* language).

Indeed, Judge Arnold-Burger of the Kansas Court of Appeals somewhat recently explained:

> "before we may strike down a statute, we must first determine whether it clearly violates the defendant's rights secured by the Constitution. If it does, we look to whether the statutory infringement or limitation on that right is acceptable. **To determine if it is an acceptable infringement on a constitutional right, we look to see if the infringement can meet the proper constitutional test**."

State v. Foster, 60 Kan.App.2d 243, 259-60, 493 P.3d 293, 294 (2021) (Arnold-Burger, concurring) (internal citation omitted) (emphasis added); accord *State v. Hall*, 65 Kan.App.2d 369, 380-89, 564 P.3d 786, 794 (2025) (noting the Kansas Supreme Court's analytic framework for evaluating facial challenges in cases involving fundamental rights violations and applying strict scrutiny to determine constitutionality).

This is exactly the approach used in *Hodes I* and its progeny, where the Court noted that the presumption of constitutionality is removed, and the applicable constitutional standards/tests must be applied. See *Hodes I,* supra at 673 ("courts peel away the protective presumption of constitutionality and adopt an attitude of active and critical analysis, subjecting the classification to strict scrutiny"; *Hodes II* supra at 1011 (after establishing infringement, "burden shifts to the State to defend the law under strict scrutiny"); *and Hodes III* supra at 950-51("the State must show that any infringement of that right [to bodily autonomy] withstands strict scrutiny."). Nowhere in any of those majority opinions is the "no set of circumstances" language expressly referenced, much less used as an overarching or separate constitutional test. Thus, it appears that in Kansas, facial challenges to statutes (or other affirmative law) that actually infringe on citizens' fundamental rights must be exclusively evaluated under the applicable constitutional framework.[82] If they fail that requisite test, then the enactment is facially unconstitutional. In those circumstances, the failure to demonstrate that the law passes constitutional muster *describes* a situation where there truly are "no set of circumstances" under which it can be constitutionally applied.

Given what the Court considers binding precedent and persuasive authority from a wide array of federal circuit courts of appeal, district courts, and scholarly commentators, the Court has applied above the requisite constitutional framework (strict scrutiny) to the issues and claims presented, as it believes is contemplated and required

[82] Arguably, the analysis applies to all cases asserting facial unconstitutionality and the presumption of constitutionality of statutes/laws subjected to "rational basis" review renders the "no set of circumstances" concept a more relevant "test" or "standard"—given the underlying nature of such statutes or other law. It is not only a description of the outcome of the constitutional analysis but also reflects the difficult nature of the task to prevail in such matters.

by Kansas law and by better reasoned federal precedent. See Section IV.B.; IV.C.; and IV.D, supra. Under those tests, the Subject Laws cannot pass constitutional muster. *Id.* The Subject Laws expressly infringe upon both the Provider plaintiffs' fundamental rights to free speech, as guaranteed by Section 11 of the Kansas Constitution's Bill of Rights and the providers' patients' rights to bodily autonomy guaranteed by Section 1, and they fail strict scrutiny review. Thus, there are "no set of circumstances" under which these legislative schemes can be constitutionally applied.

Lastly, it is of no import that the State Defendants point to admitted evidence that some women might be agreeable to either the State's mandated message or procedure required by the Subject Laws. The Court has considered the evidence provided by various State witnesses regarding whether those individuals, in retrospect, would have found either the substance of the mandatory disclosures or the mandatory delays required by the Subject Laws to be "helpful" to them in making their pregnancy-related decisions.[83] Yet, their subjective and biased thoughts, provided in hindsight, cannot alter the Court's conclusions regarding the analytic framework required in Kansas for such laws. Rather, the proper focus for constitutional scrutiny is "the group for which the law is a restriction, not the group for whom the law is irrelevant." See *State v. Ryce*, supra at 915-16. Their testimony does not support a conclusion or inference that there are circumstances in which the Subject Laws can be constitutionally applied, even if it were credible and entitled to substantial weight.

[83] The Court has expressly addressed the weight and credibility of those witnesses above. It found those witnesses' testimony entitled to essentially no weight.

Indeed, there could well be some women and some physician providers for whom the constitutional infringements prescribed by the Subject Law would be welcomed or, at least tolerated, without objection. However, that theoretical subgroup is not the relevant perspective or group, from a constitutional standpoint. The Subject Laws violate the rights of ***all*** pregnant women to the extent they seek to consider terminating their pregnancy and of ***all*** abortion providers', even if some of those groups might not mind or object to the impairment. As such, from a constitutional standpoint, there are no set of circumstances where the Subject Laws can be constitutionally applied to the *relevant* group of individuals affected. The State Defendants have demonstrated neither an adequate legal rationale nor evidentiary basis for upholding the Subject Laws, on this record, and their *Salerno* references do not alter this conclusion.

G. The Subject Laws and their requirements are, in part, severable, so certain provisions may properly survive.

Because the disclosure and "informational" provisions (including the mandatory waiting period provisions) of the WRTKA, including the Reversal Mandate, and the interrogation provisions of the Reason Mandate are unconstitutional, the Court now turns to whether those offending provisions are severable, such that the remainder of the laws survive. The Provider plaintiffs argue that the Subject Laws are simply not severable because they are inextricably linked and because the laws would not have been enacted, absent the invalid provisions. The State Defendants counter that the WRTKA and the Reason Mandate are salvageable, in whole or in part, because many of the WRTKA provisions are "purely technical" in nature and because the Reason Mandate simply furthers the collection of data for "public health surveillance".

Hinging on legislative intent, the severability test is well-established. If (1) the Legislature would have passed the challenged laws absent the objectionable portions, and (2) if the challenged laws can effectuate the intent of the Legislature without the objectionable portions, a court may sever the unconstitutional provisions and leave the remaining provisions intact. *Gannon v. State*, 304 Kan. 490, 523-525, 372 P.3d 1181, 1201-1202 (2016); *Brennan v. Kansas Ins. Guar. Ass'n*, 293 Kan. 446, 463, 264 P.3d 102, 114-15 (2011) ("whether the court may sever an unconstitutional provision from a statute and leave the remainder in force and effect is a question of legislative intent.").

While the presence of a severability clause provides evidence of legislative intent, it "is an aid merely, not an inexorable command." *Gannon v. State*, 304 Kan. 490, 520, 372 P.3d 1181, 1199-1200 (2016) (severability clause creates presumption of severability);*State ex rel. Morrison v. Sebelius*, 285 Kan. 875, 913, 179 P.3d 366, 391 (2008) (severability argument stronger where act has a severability clause).

Kansas courts have repeatedly declined to sever invalid portions of laws, even when they contain a severability clause. *Gannon*, supra at 1200 (citing several Kansas Supreme Court and United States Supreme Court cases in support of non-severability). This is especially true when doing so would change the scope of the challenged act or when the provisions are so intertwined that severing would be fruitless. See *Sebelius*, 285 Kan. at 914 (act's plain language "answered the question" of severability by enumerating only one triggering condition despite presence of general severability clause); *State ex rel. Marshall v. Consumers Warehouse Market*, 185 Kan. 363, 372, 343 P.2d 234 (1959) ("[t]he invalid portion of the statute is not a separate and independent provision of the Act, but rather is such an integral and inseparable part of

the whole scheme and purpose of the law that it may not be severed therefrom and thus leave the remainder in full force and effect. In other words, to eliminate the objectionable exemption would change the scope of the Act."); *City of Wichita v. Trotter*, 316 Kan. 310, 514 P.3d 1050 (2022) (impossible to sever due to interconnectedness); *State v. Arnett*, 314 Kan. 183, 496 P.3d 928 (2021) (same); *State v. Robison*, 314 Kan. 245, 496 P.3d 892 (Kan. 2021) (same). The decision to sever is not to be taken lightly; care must be taken to ensure legislative power is not supplanted. *Sebelius*, 285 Kan. at 915; see also *Barr v. Am. Ass'n of Pol. Consultants, Inc.*, 591 U.S. 610, 626-27, 140 S. Ct. 2335, 2350-51, 207 L. Ed. 2d 784 (2020) (courts are often not in a position to understand the true intent of Congress or the President and should therefore err on the side of "surgical severance rather than wholesale destruction" out of respect for the separation of powers).

In this case, the Court is required to evaluate, given its findings and conclusions that the Subject Laws are (in many respects) unconstitutional, whether the offensive and infirm provisions can be severed from the remainder of the laws to effectuate the legislative intent. Each of the Subject Laws must be analyzed separately.

WRTKA:

As described above, the WRTKA, by its plain language, appears to have originally been enacted to specifically govern and dictate the exact details of "informed consent" provided by a small subset of health care providers to their patients seeking this specific medical procedure/care. In that regard, it stands essentially alone under Kansas law in its substance regarding "informed consent." The provisions and requirements of the WRTKA became increasingly more detailed, less accurate, and

more burdensome over time, culminating in the current existing version that is at issue. It includes obligations and/or impediments for patients, for physician providers/clinics, and for the KDHE. The plain language of the law suggests that its original intent was to provide pregnant women that were seeking to terminate their pregnancies with information that the State believed they needed and had a "right to know." The State Defendants have contended that this "enhances" autonomy and "upholds" the integrity of the medical profession. See Pretrial Order, Index No. 630, pg. 28.

The WRTKA included a severability provision amongst its substance, which provides:

> "The provisions of this section are declared severable, and if any provision, phrase or clause or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the remaining provisions, phrases or clause or the application thereof to any person or circumstance."

K.S.A. 65-6714 (2025).

The invalid portions of the WRTKA relating specifically to the providers'/patients' obligations are simply not severable from each other under existing Kansas precedent. The Court understands the Legislature provided a "severability" clause as an "aid" to its intent and desire to ensure it remained—in the event any of the law was declared invalid. However, this interpretive aid cannot overcome the Kansas legal requirements for severability, at least as it relates to any of the litany of mandatory disclosure or delay requirements imposed on patients and/or physician providers, such as plaintiffs.

The WRTKA's disclosure requirements for health care providers are essentially a unified and comprehensive effort to dictate to physicians providing this singular type of care (abortion) how they must advise their patients on this deeply personal,

individualized, and complex choice/decision. Its broad patchwork approach towards providers' crucial confidential interactions with their abortion patients requires temporal delays, mandatory "giant" signs in clinic office waiting rooms and exam rooms, and voluminous written and other disclosures to the patients that are of questionable accuracy and/or materiality to most patients. The individual disclosure requirements for health care providers are NOT isolated and/or independent aspects of a broader legislative scheme/plan, which can be effectively "carved out" from otherwise permissible provisions relating to providers; they **are** the scheme—essentially in its entirety.

It is unfathomable to the Court that there would even be any provider regulation in this vein, absent the invalid provisions. Rather, the WRTKA, with its various additions over time, is a unified and inextricably-linked effort to overwhelm physician providers and their patients seeking an abortion and to, in the process, alter the decision-making process for pregnant women that wish to terminate their pregnancy. The invalid provisions (which are many) are inseparable, and there is nothing that would remain of the disclosure and mandatory delay portions, in any carve-out of the provisions. Thus, the Court concludes that the invalidated portions of the WRTKA, related to physician disclosure and patient delays, are NOT severable from one another and that the entire scheme simply does not survive constitutional scrutiny.

Having said that, the Court notes that a specific part of the WRTKA, K.S.A. 65-6710, mandates that KDHE (and only the state agency) create and maintain various informational matters on its official agency website and in printed form to be available to the public. See K.S.A. 65-6710(a)(1), (2), (3), (5), (b), and (c) (2025). To the extent that

the State, as a policy choice, deems this information relevant and/or important for women to "know" as part of making reproductive health choices, it would appear that that specific aspect of the law[84] (and only that aspect) may survive and can effectuate the State's underlying goal/purpose and permissibly further its intent and preferred outcomes. Even if one concludes the disclosures are, in part, inaccurate, potentially misleading, and medically irrelevant to most women pondering an abortion, the State does not unconstitutionally act to violate any natural or fundamental right by simply making such matters available for voluntary consideration by the public. Indeed, the Court has noted that the State is certainly free to advance its own informational campaigns with whatever permissible messages it deems appropriate, otherwise lawful, and non-actionable.

What it may not properly do is what the remainder of the WRTKA does: compel physician providers in this limited circumstance to speak the State's preferred messaging and compel pregnant women seeking to terminate a pregnancy (and only those women) to delay or forego care until after being subjected to the State's message—purely based upon the State's preferred outcome. Thus, the Court will sever K.S.A. 65-6709; 65-6710(a)(3), to the extent it notifies the public of the physician's "require[ments] on disclosures or potential consequences to him/her/them; 65-6710(a)(4) regarding physician certification forms, and 65-6712 that defines and modifies "unprofessional conduct" for physicians. Those portions of the WRTKA are constitutionally infirm and cannot survive.

[84] The particular agency-specific provisions that require only it, as an agency, to provide disclosures and information that a patient, provider, pregnant woman, or any other individual may ***voluntarily*** consider. See K.S.A. 65-6710(a)(1), (2), part of (3), (5), (b), and (c)

The remaining provisions of the WRTKA, which primarily relate to the State's own voluntary messaging, can be constitutionally preserved to accomplish, to the extent permissible, what appears to be the original legislative intent. This conclusion harmonizes the inherent tension between the invalid provisions that encroach upon the constitutional rights of patients and their chosen health care providers and those portions that permissibly attempt to further the legislature's intent and potentially legitimate interests—without interfering with such fundamental rights. And it reflects appropriate deference to the separation of powers that our state Constitution requires.

APR Mandate:

The analysis and conclusion with respect to the 2023 supplement to the WRTKA, the APR Mandate, is identical in nature and extent. This supplemental legislation/enactment (now K.S.A. 65-6716) is a unified and integrated set of requirements directly aimed at the provision of information regarding APR theory, as described above. The overwhelming majority of that new enactment is targeted at provider obligations to inform their abortion patients (and frankly anyone entering their offices, whether they are there for an abortion or not) of the existence and particulars of this unproven theory that the State wishes to espouse as mainstream medicine. However, there is a subsection that, like the broader WRTKA, only entails publishing data on state-agency websites, namely subsection (e). It provides:

> (e) Within 90 days after the effective date of this section, the department of health and environment shall cause to be published, in English and in each language that is the primary language of 2% or more of the state's population, in print and on the website required to be maintained under K.S.A. 65-6710, and amendments thereto, comprehensible materials designed to inform women of the possibility of reversing the effects of a medication abortion that uses mifepristone and information on resources

> available to reverse the effects of a medication abortion that uses mifepristone. The website shall also include other relevant telephone and internet resources containing information on where the patient can obtain timely assistance to attempt to reverse the medication abortion.

K.S.A. 65-6716 (e) (2025).

The APR Mandate also contains, like the broader WRTKA, a severability clause, with substantially-similar language to the WRTKA. See K.S.A. 65-6716 (j) (2025).

Outside of subsection (e), all provisions of the APR Mandate are unconstitutionally infirm and are invalidated herein. The overwhelming majority of the APR Mandate seeks to compel providers to speak on such issues and tacitly endorse this unproven theory that endangers women, and it seeks to punish or chill those that refuse to comply by way of its various civil, criminal, and administrative penalties. Thus, they are unconstitutional for the reasons set forth in greater detail above.

However, as with the prior version of the WRTKA, the offending provisions in K.S.A. 65-6716 can be severed, pursuant to subsection (j), and the remaining state-agency publication provision (subsection (e)) can survive to effectuate, in part, the Legislature's intentions and interests, whatever those might be,[85] so as to provide access to this data in a voluntary and constitutional manner.

This Court has grave reservations and concerns about the use of APR theory, having carefully considered the available credible medical evidence. It is a statutory scheme that, more likely than not, makes pregnant women less safe and less knowledgeable—not more. However, the issue of whether this is a good policy choice

[85] The Court will assume, without finding, that the purported interest for this amendment is "respect for potential life" and that such an interest is legitimate, even though the State Defendants have failed to affirmatively demonstrate those facts—in the Court's view.

or a suspect one is better left to the Legislature and our elected representatives in that branch of government—*to the extent that it is exercised through voluntary dissemination* and does not otherwise infringe upon the fundamental rights of Kansans or those within its borders seeking care. As such, the Court affords proper deference to the Legislature and will sever and invalidate all but subsection (e) of the APR Mandate (K.S.A. 65-6716), as part of its ruling. All portions of the APR Mandate, outside of section (e), are hereby invalidated and deemed unconstitutional.

Reason Mandate:

The Reason Mandate, which was enacted in 2024 but has yet to become effective, seeks to amend the prior version of K.S.A. 65-445. The original version of K.S.A. 65-445 required and regulated the collection of very basic, de-identified, demographic information relating to pregnant women terminating their pregnancies. See K.S.A. 65-445 (2024). KDHE, for vital statistics purposes, was charged with determining the information generally required for its annual reporting, other than certain specifics prescribed by the legislature. See K.S.A. 65-445(f) (2024). It required an annual report from physicians performing abortions, which was then transmitted to KDHE for confidential retention and for potential use in reporting regarding abortion vital statistics in Kansas, amongst myriad other vital statistics for the state. See prior subsections (c)-(g).

The amended version of K.S.A. 65-445, which includes the new Reason Mandate requirements, has been described at length herein. In a nutshell, the new provisions seek additional data through the use of invasive and stigmatizing mandatory questioning by the conscripted health care provider. See H.B. 2749 and K.S.A. 65-445

(2025). This data is not typical of "vital statistics" and was not the result of requests, input, or consultation by the KDHE (or any other public health professional organization, agency, or individual), prior to enactment. FOF, ¶¶ 46, 233-43. Currently, there is no anticipated or intended use by KDHE for the data contemplated by these new requirements. FOF, ¶¶ 253-55. The Reason Mandate also added a severability clause, which states:

> "(k) The provisions of this section are declared severable. If any provision, phrase or clause or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the remaining provisions, phrases or clause or the application thereof to any person or circumstance."

K.S.A. 65-445 (2025).

The original statutory language of K.S.A. 65-445, which was amended and revised in 2024 by our Legislature, was intended to provide data for basic vital statistics purposes to be published and used by the KDHE for its specific public health purposes. See K.S.A. 65-445 (2023). Indeed, Kansas (through KDHE) appears to have collected and published basic statistical data, as originally contemplated by KDHE and other public health experts, for many years. The Legislature, through its severability clause in this case, undoubtedly intended that the original provisions and basic vital statistics data collection continue, if the Reason Mandate was invalidated. The Court finds the intent of the original statute and the Legislature's intent (as expressed in subsection (k)) not to lose this basic data collection process for purposes of compiling simple and common vital statistics is clear, particularly in light of the severability provision that aids this Court's view of this particular law.

The original version of K.S.A. 65-445, which was non-controversial and basic vital statistics data for the KDHE's use (and with their input), has an intent and legitimate purposes that can be properly effectuated without the suspect and invalid provisions of the Reason Mandate, which effectively replaced the original statute. As such, the Court will sever the constitutionally-infirm and invalid provisions of 65-445, enacted in 2024, and concludes that the substantive provisions that gather basic vital statistics data points (See prior ITOP form, Pltf's Ex. 6a), which were contained within the original version of K.S.A. 65-445, should survive.

H. Permanent Injunctive Relief, as it relates to the Subject Laws, is appropriate and necessary.

As noted above, the Court previously granted a preliminary/temporary injunction as to the WRTKA and H.B. 2264. See Court's Temporary Injunction dated October 30, 2023; Index No. 630.[86] In doing so, the Court concluded that the plaintiffs were likely to prevail on their claims against the State Defendants and that the balance of the remaining factors weighed in favor of a preliminary injunction. *Id.* Given the foregoing analysis, the Court now turns to the issue of plaintiffs' related request for permanent relief, in the form of a permanent injunction.

The standards governing a permanent injunction under Kansas law are extremely similar to the standards governing a temporary injunction. The primary distinction is that the plaintiff, rather than showing ***a likelihood of success*** on the merits, must ***actually succeed*** on the merits at the permanent injunction stage. See

[86] By agreement, the parties also entered into a Stipulation to forego enforcement of (and to effectively enjoin) the later-enacted statute, H.B. 2749. See Index No. 137. This stipulation also followed the parties' prior stipulations to enjoin the WRTKA, ultimately until final disposition in this case. See Index No. 38, 99.

Downtown Bar and Grill v. State, 294 Kan. 188, 191, 273 P.3d 709 (2012); *Steffes v. City of Lawrence*, 284 Kan. 380, 395, 160 P.3d 843, 853 (2007) ("As a result, to receive a permanent injunction, 'the plaintiff must actually succeed on the merits.'") (citation omitted); *Roll v. Howard*, 59 Kan. App. 2d 161, 175, 480 P.3d 192, 203 (2020).

Though the success on the merits weighs heavily in favor of issuing a permanent injunction, the person seeking injunctive relief must also demonstrate that the absence of an injunction would lead to irreparable harm; that no adequate legal remedy exists to address the person's claim; that the person's injury would outweigh the harm any injunction may cause to the opposing party; and that the injunction, if issued, would not be adverse to the public interest. See *Downtown Bar and Grill v. State*, 294 Kan. 188, 191, 273 P.3d 709 (2012); *Steffes v. City of Lawrence*, 284 Kan. 380, 395, 160 P.3d 843, 853 (2007); *Husky Ventures, Inc. v. B55 Investments, Ltd.*, 911 F.3d 1000, 1011 (10th Cir. 2018) (listing standards for obtaining a permanent injunction under federal law).

In the case at bar, the Court has concluded that plaintiffs have, in fact, actually succeeded on the merits of several of their claims. Namely, they have prevailed on their claims for violations of Sections 1, 2, and 11 of the Kansas Constitution. And much like the conclusions reached as part of its temporary injunction, the Court concludes herein that plaintiffs also have demonstrated, more likely than not, that the other equitable factors weigh in favor of permanent injunctive relief.

First, there is little question that, in the absence of injunctive relief that precludes the State from further enforcement of the Subject Laws, the plaintiffs will suffer irreparable injury. The evidence adduced at trial more than sufficiently demonstrates that plaintiffs, their staff, and their pregnant patients wishing to terminate their

pregnancies will all suffer substantial harm and infringements of their Constitutional rights under the Kansas Constitution's Bill of Rights. Those injuries and infringements are adequately set forth above, see Sections IV.B through IV.D, *supra*. Simply stated, absent permanent injunctive relief, Kansas women's inalienable natural and fundamental rights to bodily autonomy will be irreparably infringed upon (whether through unjustifiable delay and obstruction or through outright denial of their individual rights to assert their own bodily autonomy and make their own independent decisions regarding pregnancy). Furthermore, enforcement of the Subject Laws will similarly impose cascading and irreparable injuries on the plaintiff health-care providers forced to comply with the State's mandates by infringing on those providers' rights to free speech. And the Subject Laws also necessarily inflict logistical, emotional, and economic harms upon them as a uniquely-situated group of medical professionals that have been singled out by the Subject Laws.

Next, enforcement and the continued viability of the Subject Laws leaves the plaintiffs without any adequate or meaningful remedy at law. There is no meaningful way to address such infringements after the fact, nor any way to "turn back the clock" and restore such rights to a pregnant woman, particularly those seeking to assert their decision-making rights close to the various time limits for medication abortion or for surgical abortions near gestational age limits in Kansas. Similarly, there is no adequate remedy for health-care providers that are forced to speak the State's messaging, in contravention to their ethics and professional judgment. Once uttered, those words cannot be clawed back, and the confidential relationships with those patients are, thus, likely undermined and altered. No relief short of permanent injunctive relief can

alleviate the harms inflicted, no matter how much the State Defendants would like to argue that such actions can be "reversed." They simply cannot be.

And the record demonstrates that injunctive relief provides and will likely continue to provide a meaningful remedy in this case. Since the entry of this Court's temporary injunction, plaintiffs' patients have not been subjected to unnecessary and undesired delays, informational overload, traumatizing or stigmatizing discussions, or hyper-technicalities that plague the Subject Laws. Nor have the providers been forced to choose between speaking the State's mandated messaging and properly tailored patient-centric care, provided in accordance with generally-accepted standards of professional care. Rather, Plaintiff providers and their patients have been able to effectively provide and receive standard-of-care medicine without unconstitutional impediments since October of 2023. The proof that there is no other adequate remedy and that injunctive relief is adequate is in this proverbial pudding. See FOF, ¶ 192

Additionally, constitutional violations to the plaintiffs (and their patients) obviously outweigh any remote or hypothetical harm to the State Defendants, which further supports the imposition of a permanent injunction. Indeed, the Court can conceive of no ***legitimate*** harm to the State Defendants, if injunctive relief is granted. Those state officials and agencies will be free to act and perform their ***valid and lawful*** statutory functions and duties, even with injunctive relief imposed with respect to the Subject Laws. This is particularly true in light of the Court's rulings regarding severability of the offensive provisions. Permanent injunctive relief would ***only*** result in a prohibition on enforcing unconstitutional laws and conduct, such as the Subject Laws, and such

limitations cannot be considered cognizable "harm" to the State Defendants under any reasonable definition.

Finally, balancing of the plaintiffs' interests (and those of their patients) against the legitimate "public interests" also weighs in favor of a permanent injunction in this case. The issues raised herein implicate very real and very private and personal decisions regarding a pregnant woman's bodily autonomy and the important, close, and confidential relationship between such women and their health-care providers. Those rights are fundamental and critically important. While the State Defendants have put forth various "interests" they contend underlie the Subject Laws and contend are reflective of the "public interest," they simply do not rise to the level of compelling governmental interests—to the extent that they are even legitimate interests. See Analysis, Section IV.B, supra. Balancing the plaintiffs' critical and fundamental interests against those interests that, at least at the stages of a pregnancy at issue in this matter, simply do not rise to the level of compelling, it is clear and obvious to the Court which way the "scales" tilt in this case. A permanent injunction is not adverse to the public's interest, which is best served by protecting the individual liberties of its citizens and of those within the state's borders. Instead, injunctive relief furthers the public's broad interests favoring individual liberty and autonomy, even where it invalidates a legislative

policy pronouncement—when enacted in contravention to such principles.[87]

In light of all the foregoing, permanent injunctive relief is both necessary and appropriate, as it relates to the Subject Laws, given their unconstitutional nature. Thus, the Court hereby permanently enjoins the State Defendants,[88] as follows:

> 1. Except as described below, the State Defendants may not enforce the provisions and requirements of K.S.A. 65-6709, 65-6710(a)(3) and (a)(4), 65-6712; H.B 2264 (now codified as K.S.A. 65-6716); or H.B. 2749 (amending and partially replacing K.S.A. 65-445). This Court finds them to be unconstitutional, unlawful, and unenforceable. This permanent injunction includes specifically:
>
> a. The mandatory disclosure requirements (including oral, written, or other visible disclosures) expressly set forth in K.S.A. 65-6709 that are imposed upon plaintiffs or other similarly-situated providers of abortion care within the State of Kansas. Neither plaintiffs nor other similarly-situated licensed health care providers shall be required to comply with (nor may the State require) these requirements to communicate the State's preferred disclosures;
>
> b. The mandatory waiting period provisions (whether 24-hour minimum or 30-minute minimum) expressly set forth in K.S.A. 65-6709. Neither plaintiffs nor other similarly-situated licensed health care providers shall be required to comply with (nor may the State require) these requirements;
>
> c. Those portions of K.S.A. 65-6710 that relate to required physician certification that abortion patients have been advised of the disclosures, as prescribed, and any corresponding certification form. Physicians shall not be required to provide such disclosures, forms, or ensure execution and preservation of such forms, as of the effective date of this Judgment. Nor are they required to certify the provision of such information, and the State Defendants shall not publish any information, as contemplated in K.S.A. 65-6710(a)(3), indicating that discussions expressly contained with the WRTKA are required of health care providers;

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[87] Notably, Kansans, in 2022, previously spoke on this very issue and articulated what they apparently perceive to be their broader public interests as citizens. As mentioned in the Court's Order granting a Temporary Injunction, Kansans broadly reaffirmed its commitment to the right of women to exercise bodily autonomy when it rejected a legislatively-proposed Constitutional amendment placed on the ballot. If passed, the change would have eliminated that right to make decisions on proceeding with or terminating a pregnancy, as part of the fundamental right to bodily autonomy under our state constitution. But that proposed amendment was voted down by the electorate—with just short of 60% voting ***against*** the amendment. Thus, it is reasonable to conclude that the broader "public interest" in Kansas is actually served by the permanent injunction, given the citizens' overwhelming decision to reaffirm this right.

[88] In accordance with K.S.A. 60-906, this Judgment is also binding on the State Defendants' "officers, agents, servants, employees, and attorneys, and upon those persons in concert or participating with them who receive actual notice".

d. The provisions defining and dictating that non-compliance with the "Woman's-Right-to-Know" Act constitute "unprofessional conduct" under the Healing Arts Act, including K.S.A. 65-2837 are hereby enjoined and this Court finds them to be unconstitutional, unlawful, and unenforceable, and the Board of Healing Arts is hereby prohibited and enjoined from taking action under the Healing Arts Act that would be inconsistent with this Court's findings and rulings set forth herein;

e. The mandatory disclosure requirements (including oral, written, or other visible disclosures) expressly set forth in H.B. 2264 (now K.S.A. 65-6716) that are imposed upon plaintiffs or other similarly-situated providers of abortion care within the State of Kansas. Neither plaintiffs nor other similarly-situated licensed health care providers shall be subject to or required to comply with (nor may the State require) H.B. 2264's requirements to communicate the State's preferred disclosures.

f. The mandatory questioning and reporting requirements established by H.B. 2749 (now codified as the amended and replaced K.S.A. 65-455), as it relates to the "most important reason," as prescribed in subsection (c) of the amended statute, K.S.A. 60-445 and as it relates to the provisions of subsection (d) (additional mandatory inquiries). Neither plaintiffs nor other similarly-situated licensed health care providers shall be subject to or required to comply with (nor may the State require) H.B. 2749's requirements under these subsections.

g. Nothing in this permanent injunction shall prohibit substance of the prior version of K.S.A. 65-445 from being enforced or effective, as the Court finds the original statutory language and law, which was amended and replaced by the Reason Mandate (in part), are severable from the invalid portions described herein.

h. Nothing in this permanent injunction shall prohibit KDHE from posting information as contemplated in the surviving provisions of the WRTKA or the APR Mandate (see above) on its own website for *voluntary consumption/review by the public*.

Plaintiffs are responsible for serving this Order, as required by law, on any interested parties.

V. Conclusion

This Court has great respect for the deeply-held beliefs on either side of the broader and contentious social issues presented in this case. Nevertheless, the Court is obligated and charged with applying binding Kansas law to the facts of the case. And, indeed, as the Court indicated when ruling on the prior request for a temporary

injunction, the State's capacity to legislate pursuant to its own moral scruples is necessarily curbed by the Kansas Constitution and its Bill of Rights. The State may pick a side and a viewpoint, but in doing so, it may not trespass upon the inalienable natural and fundamental rights of the people. In this case, the record before the Court clearly and unequivocally demonstrates that the Subject Laws impair and unconstitutionally infringe upon Kansans' natural and fundamental rights under Sections 1, 2, and 11 of the Kansas Constitution Bill of Rights.

This Court treads carefully and with proper respect and deference to the Legislature when evaluating the validity of state laws; however, it also must act in light of the Kansas Supreme Court's consistent admonition:

> "[t]he judiciary ... has imposed upon it the obligation of interpreting the Constitution and of safeguarding the basic rights reserved thereby to the people." Harris, 192 Kan. at 206, 387 P.2d 771. So ***"when legislative action exceeds the boundaries of authority limited by our Constitution, and transgresses a sacred right guaranteed or reserved to a citizen, final decision as to invalidity of such action must rest exclusively with the courts.***" (Emphasis added.) 192 Kan. at 207, 387 P.2d 771."

Hodes I, supra at 682 (citing Justice Fatzer's opinion in *Harris*) (emphasis added).

Accordingly, for all of the reasons set forth herein, the Subject Laws must be invalidated, in large part, and severed because they violate the inalienable natural and fundamental rights of Kansas women to exercise her bodily autonomy with respect to her pregnancy during the pre-viability period and because they also infringe upon the Provider plaintiffs' fundamental right to free speech. The Court hereby grants a Permanent Injunction as to these Subject Laws, consistent with the Court's ruling set forth above.

IT IS SO ORDERED, ADJUDGED, AND DECREED.

This Journal Entry of Judgment constitutes a final Order/Judgment for all purposes, including for purposes of appeal.

Dated: This 3rd day of August, 2026.

K. Christopher Jayaram

The Honorable K. Christopher Jayaram
Judge of the Johnson County District Court
Division 12

NOTICE OF ELECTRONIC SERVICE

Pursuant to K.S.A. 60-258, as amended, copies of the above and foregoing order of the Court have been delivered via electronic transmission through the Centralized Case Management System (CCMS) automatic notification electronically generated upon filing of the same by the Clerk of the District Court to the e-mail addresses provided by counsel of record in this case. Counsel for the parties so served shall determine whether all parties have received appropriate notice, complete service on all parties who have not yet been served, and file certificate of service for any additional service made.

_____/s/ Corey Jobe_____
Corey Jobe
Administrative Assistant
Division 12