IN THE DISTRICT COURT OF OKLAHOMA COUNTY
STATE OF OKLAHOMA

MAGON HOFFMAN; SHEENA HAMLIN; OKLAHOMA CALL FOR REPRODUCTIVE JUSTICE, on behalf of itself and its members; ELIZABETH PINARD, M.D., on behalf of herself and her patients; and SARAH MASHBURN, M.D., on behalf of herself and her patients,

Plaintiffs,

v.

GENTNER DRUMMOND, in his official capacity as the Attorney General of the State of Oklahoma; VICKI BEHENNA, in her official capacity as the District Attorney for Oklahoma County; SANDRA HARRISON, in her official capacity as the Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; STEVEN K. MULLINS, in his official capacity as the Executive Director of the Oklahoma State Board of Osteopathic Examiners; and KEITH REED, in his official capacity as the Commissioner for the Oklahoma State Department of Health,

Defendants.

Case No. _____
Hon. _____

VERIFIED PETITION

Plaintiffs, by and through their undersigned attorneys, bring this Petition against the above-named Defendants, their employees, agents, and successors in office ("Defendants" or "the State"), and in support thereof allege the following:

I. PRELIMINARY STATEMENT

1. Every year, many pregnant Oklahomans receive a diagnosis that means their pregnancy will end in miscarriage, stillbirth, or the death of an infant shortly after birth. Pregnant people should have the freedom to discuss these circumstances with doctors and loved ones, decide

on the best course of action, and effectuate their decision, free from stigma or discrimination. But that is not the reality that Oklahomans face.

2. Instead, Oklahoma's abortion bans, 21 Okla. Stat. § 861 (the "Total Ban") and 63 Okla. Stat. § 1-745.5 (the "22-Week Ban") (collectively, the "Bans") (attached hereto as Exhibits A and B, respectively), force these Oklahomans to remain pregnant or leave the state if they can. This is a deeply personal time, involving complex decision-making by the pregnant person about what is best for themselves and their families—decisions that implicate questions central to one's identity and beliefs. But the Bans take away pregnant Oklahomans' ability to act on their own decisions. Instead, every patient who receives a fatal fetal diagnosis is forced into the *State's* idea of the best way forward: continuing the pregnancy and giving birth, despite the likelihood of miscarriage, stillbirth, or watching a newborn die shortly after birth. The Bans require these Oklahomans to continue to carry a pregnancy that will not result in a child they can take home, which can traumatize both pregnant people and their families.

3. This is precisely what happened to the patient plaintiffs in this case. Magon Hoffman and Sheena Hamlin each became pregnant in Oklahoma after the Bans went into effect. Each received a diagnosis that meant that her pregnancy was effectively nonviable. But, in Oklahoma, they were not permitted to get an abortion even though being forced to continue their pregnancies had major negative impacts on their bodily integrity, decisional autonomy, mental and emotional health, and future family formation.

4. This flies in the face of "the right of an individual to make decisions about her life" and the "respect for the dignity and autonomy of the individual" protected by the Oklahoma Constitution. *In re K.K.B.*, 1980 OK 7, 609 P.2d 747, 752. The Bans violate pregnant Oklahomans' fundamental rights to life and liberty, their substantive due process rights, and their rights to equal

protection. Oklahoma has *no interest whatsoever* in forcing these patients to continue their pregnancies and give birth, and it therefore cannot justify this interference with fundamental rights. Indeed, forcing these Oklahomans to continue their pregnancies lacks even a rational basis. The Bans are unconstitutional as applied to people whose pregnancies have been diagnosed with a fatal fetal condition.

5. The Oklahoma Supreme Court recognized that Oklahomans have a fundamental right to life-preserving abortions in March 2023. *Okla. Call for Reprod. Just. v. Drummond (OCRJ I)*, 2023 OK 24, ¶ 12, 526 P.3d 1123, 1131. It has reaffirmed that precedent twice. *Okla. Call for Reprod. Just. v. State (OCRJ II)*, 2023 OK 60, ¶ 7, 531 P.3d 117, 123; *Okla. Call for Reprod. Just. v. Drummond (OCRJ III)*, 2023 OK 111, ¶ 5, 543 P.3d 110, 114–15. Here, Plaintiffs seek to vindicate the same constitutional protections in asking the Court to block the Bans as applied to Oklahomans who have received a fatal fetal diagnosis.

6. Being forced to continue a pregnancy in these circumstances inflicts tremendous suffering on the pregnant patient and her family. If the patient plaintiffs in this case had not fled the state to obtain abortion care, they would have had to continue their pregnancies only to risk their health and lives to give birth to babies who were unlikely to survive birth or ever leave the hospital.

7. Plaintiffs therefore seek declaratory and injunctive relief from the Bans to ensure that no more Oklahomans with fatal fetal diagnoses are forced by the State to carry to term and deliver when their child will not survive, irrespective of the devastating impacts on their lives, health, autonomy, and well-being.

II. JURISDICTION AND VENUE

8. Jurisdiction is conferred on this Court by Okla. Const. art. VII, § 7(a).

9. Plaintiffs' claims for declaratory and injunctive relief are authorized by 12 Okla. Stat. §§ 1651 and 1381 and by the general equitable powers of this Court.

10. Venue is proper under 12 Okla. Stat. § 133 because Defendants have official residence in Oklahoma County.

III. PARTIES

a. Plaintiffs

i. Magon Hoffman

11. Ms. Hoffman found out she was pregnant in September 2022. She and her husband were thrilled. They had wanted a sibling for their daughter.

12. When Ms. Hoffman was 14 weeks pregnant, she woke up heavily bleeding. She thought she was having a miscarriage, or that something might be wrong with the baby.[1] She called her doctor, who told her to come in for an appointment the next day. In the meantime, Ms. Hoffman and her husband began thinking about how to prepare for various scenarios, including how they could support a disabled child.

13. At the appointment, Ms. Hoffman's doctor found a "huge blood clot," which, while not uncommon, was significant and the second largest he had ever seen. He told her that the "only thing to do is nothing." He told Ms. Hoffman that she just had to wait for the baby and placenta to grow, so that the placenta could flatten the blood clot and stop the bleeding. He did not give her any other options. Ms. Hoffman later learned that she had placenta previa, a condition where the placenta covers the opening of the cervix, and which can cause heavy bleeding.

[1] This Verified Petition describes pregnancy using medical terminology unless describing a particular patient's pregnancy, in which case, consistent with principles of medical ethics, it adopts the terminology preferred by the patient.

14. After the appointment, Ms. Hoffman went home. She was still bleeding, and her movement was restricted to just a step above bed rest; she could not put her daughter in her car seat, do laundry, or get groceries. Over the next several weeks, Ms. Hoffman was terrified and miserable. She continued to bleed. She went to weekly ultrasounds, where her doctor would check on her bleeding and monitor the baby.

15. At her 17-week ultrasound, Ms. Hoffman thought that her baby's growth looked unusual. Her doctor told her that the ultrasound was just to check on the bleeding and that the ultrasound machine was not rated for that gestational age—she would need the anatomy scan to get definitive results on growth. This reassured Ms. Hoffman, but she continued to think about whether her baby would need surgery soon after birth, or how she could get the best possible care and support for a child with a disability.

16. At 19 weeks, in late December 2022, Ms. Hoffman had an anatomy scan with a maternal-fetal medicine specialist ("MFM"). Ms. Hoffman could tell that the ultrasound technician knew something was wrong. The technician's measurements showed that the baby's head was measuring around 14–15 weeks, but that its body was measuring 19 weeks. When the MFM came in, he told Ms. Hoffman that her baby had anencephaly.[2] He explained that the baby had a "tiny bit of brain floating around," but "no skull." He told Ms. Hoffman her pregnancy was not viable. Her baby had no chance of survival. Ms. Hoffman was devastated.

17. The MFM then told Ms. Hoffman she had two options: leave Oklahoma and terminate the pregnancy or stay in Oklahoma and continue the pregnancy to term, while seeing the MFM for close monitoring up to 37 weeks, when she could be induced. If she chose to carry to

[2] Anencephaly is a condition in which the brain and skull do not develop as expected. Cleveland Clinic, *Anencephaly* (Aug. 29, 2023), https://my.clevelandclinic.org/health/diseases/15032-anencephaly ("Since anencephaly affects how the brain develops, babies born with anencephaly usually live only a few minutes, hours or days. Most pregnancies with anencephaly end in miscarriage or stillbirth.").

term, he told her, the baby might live for a few hours or a few days, but she would be "blind and dying." While there was nothing they could do to help the baby survive, he told Ms. Hoffman that they could provide the baby with "comfort care."

18. He then tried to convince Ms. Hoffman to carry to term. He gave Ms. Hoffman his card. He told her she didn't need to worry about contacting her obstetrician about the diagnosis; he would handle that. Ms. Hoffman was distraught. She knew there was no way she could continue the pregnancy. When she got home, she started to make plans to travel out of state. She tried calling the MFM repeatedly, but he would not return her calls. She started to feel more and more alone, isolated even from her family. She wished someone—anyone—would speak to her about her pregnancy.

19. Ultimately, she was able to make an appointment for abortion care in New Mexico. Because her insurance would not cover an out-of-state procedure, she had to pay out of pocket. In all—including travel, lodging, and childcare—Ms. Hoffman had to pay approximately $3,000. She and her husband drove eight hours to New Mexico for her appointment. Because Ms. Hoffman was later in pregnancy, the procedure took two days: Ms. Hoffman was dilated on the first day, and her pregnancy was evacuated on the second. After the procedure, Ms. Hoffman felt relieved. She was ready to be home with her family.

20. In the following months, Ms. Hoffman struggled with anxiety and depression from the loss of a pregnancy she desperately wanted and the stigma and fear she experienced in being forced to seek care out of state. She attended therapy and was prescribed antidepressants. She lost her job due to the time she took off for her abortion. Though she knew an abortion was the right choice for her and her family, Ms. Hoffman wished she had been able to obtain care in her own

state from her own doctors. Ms. Hoffman and her husband still wanted another baby, and their daughter wanted a sister, but Ms. Hoffman couldn't imagine being pregnant in Oklahoma again.

21. In June 2024, while still using birth control, Ms. Hoffman unexpectedly became pregnant for a third time. She was terrified. Tidal waves of fear prevented her from functioning. Ms. Hoffman returned to therapy and sought a supportive obstetrician. Ms. Hoffman started seeing plaintiff Dr. Sarah Mashburn for obstetrical care during this pregnancy. Magon shared her concerns with Dr. Mashburn, who supported her through the pregnancy. Dr. Mashburn helped Ms. Hoffman advocate for herself, including during routine ultrasounds by asking the ultrasound technician to narrate their findings and tell Ms. Hoffman if they were not seeing anything concerning.

22. Ultimately, Ms. Hoffman was only able to continue the pregnancy because she knew she had the resources, knowledge, and support to leave Oklahoma for care if she needed to. At no point during the pregnancy was Ms. Hoffman able to believe she would bring home a healthy baby. Instead, because she lived in Oklahoma, she spent nine months strategizing about how she would get healthcare if she found out that this pregnancy also had a fatal diagnosis. Ordinary milestones, such as ultrasounds and shopping for baby clothes, triggered feelings of intense grief in her. She could not bring herself to have a baby shower—after her prior pregnancy, none of it felt real or safe. Being pregnant in Oklahoma again came with an additional layer of terror. She and her husband had considered leaving Oklahoma to try for another baby and only then moving back to raise their family, but, with her unexpected pregnancy, there was no time to put those plans in motion.

23. Ms. Hoffman's second daughter was born in early 2025. When Ms. Hoffman ultimately delivered her baby, she felt incredible relief. Ms. Hoffman does not want additional

children. In order to protect Ms. Hoffman, her husband decided to have a vasectomy, though he would have preferred to wait. Ms. Hoffman still fears another unexpected pregnancy.

ii. Sheena Hamlin

24. Sheena Hamlin learned she was pregnant with her daughter, Ellie, in July 2024. She was shocked—it had taken some time to get pregnant with her older son—but very excited.

25. Ms. Hamlin's early pregnancy care went smoothly, though she experienced significantly more morning sickness with Ellie than she had with her older son. She had a normal ultrasound in the late first trimester, as well as an elective, non-medical ultrasound that did not raise any concerns.

26. However, when Ms. Hamlin went in for her routine anatomy scan at approximately 21 weeks, her OB/GYN, Dr. Pinard, discovered multiple unusual findings. Dr. Pinard referred Ms. Hamlin to a high-risk pregnancy specialist for a more thorough ultrasound and more information. A few days later, Ms. Hamlin met with the MFM, who told her that given all of the ultrasound findings, Ellie was "not compatible with life." The MFM suspected that Ellie had Meckel-Gruber syndrome, a lethal condition characterized by occipital encephalocele,[3] kidney cysts, scar tissue in the liver, and the presence of extra fingers and toes.

27. The MFM told Ms. Hamlin that Ellie would most likely pass in utero. She said that Ms. Hamlin could try to continue the pregnancy and that Ellie might survive until birth, but that her lungs were so severely underdeveloped that she would suffocate almost as soon as the umbilical cord was cut. The alternative would be to terminate the pregnancy. The MFM said that termination was not an option in Oklahoma.

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[3] Occipital encephalocele is a "sac-like protrusion of the brain through an opening at the back of the skull." Medline Plus, *Meckel Syndrome*, Nat'l Library of Med. (May 1, 2012), https://medlineplus.gov/genetics/condition/meckel-syndrome.

28. Ms. Hamlin and her husband agreed that they did not want their daughter to suffer, and that terminating the pregnancy was the best decision for their family. Ms. Hamlin was able to obtain an appointment for abortion care in Illinois the next week, just before Thanksgiving. Ms. Hamlin feels fortunate to have been able to access care out of state, recognizing that the cost of flights, multiple nights in a hotel, and the procedure is out of reach for many. For Ms. Hamlin, these costs were compounded by the fact that she had to fly to another state during a holiday week. In total, she spent over $4,000 out of pocket. While she received supportive, compassionate care, it was difficult to have to leave her community and support system on short notice to access needed healthcare. She struggled in the aftermath of receiving the diagnosis and losing Ellie. She knew terminating the pregnancy was the right decision for her and for her family, but she wished she had been able to access that care in Oklahoma with close family nearby. Having to leave her family—and especially her son—added another layer of stress to an already devastating situation.

29. Ms. Hamlin is currently pregnant. After her previous pregnancy, she and her husband underwent genetic testing and confirmed that Ellie had Meckel-Gruber syndrome and that they are each carriers for the Meckel-Gruber gene. Meckel-Gruber is an autosomal recessive condition, which means that each naturally conceived pregnancy between two carriers has a 25% chance of developing Meckel-Gruber, a 50% chance of the child carrying one copy of the Meckel-Gruber gene but not developing the condition, and a 25% chance of having no Meckel-Gruber gene at all. Accordingly, Ms. Hamlin and her husband pursued in vitro fertilization ("IVF") and genetic counseling to ensure that they would not have another child affected by the condition. Even despite this assurance, Ms. Hamlin has found it anxiety-inducing to be pregnant in Oklahoma again, particularly in the period leading up to the anatomy scan. Ms. Hamlin still fears an unexpected pregnancy; she knows that she could not emotionally handle another loss, though she

and her husband would make the same choice again. Her husband decided to have a vasectomy to help mitigate this risk.

30. Ms. Hamlin decided to join this lawsuit to fight for the rights of her children, and all Oklahomans, so that they might have more options and stronger legal protections than she did.

iii. Oklahoma Call for Reproductive Justice ("OCRJ")

31. OCRJ is a 501(c)(4) nonprofit founded in 2010 to advance reproductive justice and protect access to reproductive healthcare, including abortion, in Oklahoma. OCRJ is dedicated entirely to this cause. OCRJ's mission is to promote reproductive justice in Oklahoma through education, empowerment, and advocacy.

32. OCRJ pursues its mission by providing education in the community. OCRJ has published a zine, *How to Get an Abortion in Oklahoma*, providing information to Oklahomans who need to navigate the many overlapping laws restricting abortion in the state. OCRJ has also held educational campaigns, such as Faith & Abortion and Abortion is an Act of Love, to lessen the stigma attached to abortion, abortion providers, and patients.

33. OCRJ has also pursued its mission by lobbying against bills that restrict abortion and other reproductive healthcare. It supports bills that help pregnant people, including legislation barring the shackling of pregnant incarcerated patients during labor. Prior to the COVID-19 pandemic, OCRJ hosted lobby days, during which it organized its members to lobby legislators around issues of reproductive justice. OCRJ holds events and speaks to the media in order to educate Oklahomans about legislation and the potential impact of such legislation on Oklahomans' access to reproductive healthcare.

34. OCRJ supports people who need access to abortion, including by directing its educational efforts and limited resources toward educating people on the Bans and/or how to navigate barriers in other states when they need to obtain abortions outside of Oklahoma.

35. OCRJ's members are diverse in their party affiliation, economic background, and lived experience, but all believe that pregnant Oklahomans deserve the ability to make decisions about their healthcare in line with their own values and intentions. OCRJ sues on behalf of itself and its members.

iv. Dr. Elizabeth Pinard

36. Dr. Elizabeth Pinard is a board-certified OB/GYN in private practice in Oklahoma City. She provides whole-life gynecological and obstetrical care, with a particular specialty in robotic surgeries, and has delivered thousands of babies over the course of her career. Dr. Pinard sees patients from all across the state, including patients from rural communities in western Oklahoma who travel to see her for care. In addition to her private practice, Dr. Pinard volunteers at a church-run OB/GYN clinic for low-income patients.

37. Dr. Pinard grew up in Oklahoma, attended the University of Oklahoma for medical school, and returned to Oklahoma to practice after completing her residency in Texas. She is a member of the American College of Obstetricians and Gynecologists ("ACOG").

38. Dr. Pinard has cared for patients, including Ms. Hamlin, whose pregnancies have been diagnosed with fatal fetal conditions, such as renal agenesis, Trisomy 18, and Meckel-Gruber syndrome. But for the Bans, these patients could remain in Oklahoma and receive abortion care from their trusted doctors in their communities, including induction care from Dr. Pinard. After the Bans, however, these patients have been forced to travel out of state—if their circumstances permit—or to continue carrying the pregnancy, either to term or until they miscarry.

39. Dr. Pinard describes caring for these patients as "heart wrenching," and she spends a great deal of time thinking about them both inside and outside of clinic. She has helped connect patients who received fatal fetal diagnoses to a support group. It is particularly significant to her

to help care for these patients in subsequent pregnancies, to honor their experiences and to ensure that they get additional support and follow-up contact in their obstetrical care.

40. Dr. Pinard's patients have expressed fear and concern about the Bans. She has had several patients ask what their options are if they should receive a fatal fetal diagnosis during pregnancy. Some of Dr. Pinard's patients have raised these questions before even becoming pregnant.

v. Dr. Sarah Mashburn

41. Dr. Sarah Mashburn is a board-certified OB/GYN and works in a large private practice in Oklahoma City. She provides obstetrical and gynecological care, including well-woman exams, gynecological surgeries, and full-scope prenatal care from prior to conception through pregnancy, delivery, and the postpartum period. Dr. Mashburn has a particular interest in managing complex labor, including breech vaginal deliveries. She is a member of ACOG and the American Medical Association ("AMA").

42. Dr. Mashburn sees patients from all across the state, some of whom drive over two hours to see her. Because many rural areas of Oklahoma lack the resources to care for moderate- to high-risk pregnancies, many of Dr. Mashburn's patients transfer to her in the middle of their pregnancies due to concerns about their care.

43. Like Dr. Pinard, Dr. Mashburn was born and raised in Oklahoma. She attended the University of Oklahoma for medical school and returned to Oklahoma after completing her residency in Ohio. During her residency, Dr. Mashburn received abortion training, including for cases of fatal fetal diagnoses and maternal health indications like cancer.

44. During her practice in Oklahoma, Dr. Mashburn has seen several patients whose pregnancies have been diagnosed with fatal fetal conditions. One received a complex cardiac diagnosis that was deemed "incompatible with life," but nevertheless opted to continue the

pregnancy for as long as possible. Another received a diagnosis that meant that the fetus did not have an abdominal wall, and the developing organs—including the heart, liver, and lungs—were free-floating in the amniotic sac. The patient would have preferred to terminate the pregnancy but was unable to leave the state for financial and logistical reasons. She went into spontaneous early labor, and her child was provided with comfort care prior to demise.

45. Dr. Mashburn has also seen patients who have had a previous pregnancy with a fatal fetal diagnosis, including Ms. Hoffman. Dr. Mashburn understands that these patients may need additional support throughout their pregnancy, including discussion of their options should they receive another fatal fetal diagnosis. It is important to her to be able to provide this comprehensive, trauma-informed care, recognizing that every stage of a subsequent pregnancy brings new concerns, and that patients may need additional help and support around milestones like early ultrasounds and the anatomy scan.

46. Many of Dr. Mashburn's patients know that they will not be able to access abortion care in Oklahoma if they need it. Traveling out of state for care means shouldering additional financial and logistical burdens, including arranging time off of work, childcare, transportation, and lodging, in addition to finding an available appointment and funding the cost of the procedure. Delays in making these arrangements can increase the cost and the risks of the procedure: even though abortion care is very safe, the complexity of the procedure and the level of medical risk increase as the pregnancy progresses. Even for patients who have the means to seek care out of state, it would be preferable for them to be able to receive care from their doctors—who they know and trust—and to maintain continuity of care for the abortion and any necessary follow-up.

b. Defendants

47. Defendant Gentner Drummond is the Attorney General of the State of Oklahoma. The Attorney General is the "chief law officer of the state," 74 Okla. Stat. § 18, whose duties

include "appear[ing] in any action in which the interests of the state or the people of the state are at issue . . . ." 74 Okla. Stat. § 18b(A)(3). He is sued in his official capacity.

48. Defendant Vicki Behenna is the District Attorney for Oklahoma County, which includes Oklahoma City. As District Attorney, Defendant Behenna is empowered to prosecute violations of the Bans occurring in Oklahoma County. 19 Okla. Stat. § 215.4. She is sued in her official capacity.

49. Defendant Sandra Harrison is the Executive Director of the Oklahoma State Board of Medical Licensure and Supervision, which licenses physicians and has the authority to take disciplinary action against licensees for "unprofessional conduct," *see* 59 Okla. Stat. § 509, including by revoking or suspending a physician's license for committing any act in violation of Oklahoma law "when such act is connected with the physician's practice of medicine," *id.* § 509(9); *see also* 59 Okla. Stat. §§ 503, 509.1. Defendant Harrison is sued in her official capacity.

50. Defendant Steven K. Mullins is the Executive Director of the State Board of Osteopathic Examiners, which licenses physicians trained in schools of osteopathic medicine and has the authority to take disciplinary action against licensees, including by revoking or suspending licenses based on, among other things, unprofessional conduct. 59 Okla. Stat. § 637. "Unprofessional conduct" includes being found guilty in a criminal prosecution for any offense "reasonably related to the qualifications, functions or duties of an osteopathic physician." 59 Okla. Stat. § 637(A)(5). Defendant Mullins is sued in his official capacity.

51. Defendant Keith Reed is the Commissioner for the Oklahoma State Department of Health, which licenses facilities, including hospitals, at which abortions are performed and oversees compliance with regulation of such facilities. 63 Okla. Stat. § 1-737; Okla. Admin. Code § 310:600-7-3. Pursuant to this authority, the Department also regulates the provision of abortion

care in these facilities. *See, e.g.*, Okla. Admin. Code §§ 310:600-9-6, 310:600-13-3. Defendant Reed is sued in his official capacity.

IV. FACTUAL ALLEGATIONS

a. Certain fetal conditions mean that a pregnancy is unlikely to continue or result in sustained survival after birth.

52. A myriad of genetic and structural diagnoses may affect a pregnancy. Offering genetic screening and testing to pregnant patients is standard medical practice. Likewise, ultrasound screening for structural (or "morphological") indications of fetal conditions is standard pregnancy care. For example, the Society for Maternal-Fetal Medicine ("SMFM")—the leading professional organization for physicians and scientists focused on high-risk maternal and/or fetal issues—and ACOG—the nation's leading organization of physicians who provide obstetrical or gynecological care—both recommend making screening for certain genetic and structural conditions "routinely available to all obstetrical patients."[4] SMFM and ACOG both stress the importance of counseling in connection with such testing.[5] Based on the results of these screening tests, some patients may choose to pursue diagnostic testing. While screening may indicate a risk of a certain condition, more specialized testing is required for a diagnosis. Physicians, including MFMs, can diagnose fatal fetal conditions with a high degree of accuracy through ultrasound imaging or genetic testing.

53. While screening, generally through blood tests, is typically offered in the first trimester, definitive diagnostic testing is generally only available in the second trimester. Similarly,

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[4] Soc'y for Maternal-Fetal Medicine, *Society for Maternal-Fetal Medicine Consult Series #74: Cell-free DNA Screening for Aneuploidies: Updated Guidance* (Nov. 18, 2025), https://publications.smfm.org/publications/620-society-for-maternal-fetal-medicine-consult-series-74cell; Am. Coll. of Obstetricians & Gynecologists, *Practice Advisory: Screening for Fetal Chromosomal Abnormalities* (Jan. 2026), https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2026/01/screening-for-fetal-chromosomal-abnormalities.

[5] *See id.*

certain structural conditions cannot be visualized on ultrasound in early pregnancy, and many structures and functions are not sufficiently developed until the second trimester to be able to determine if there is an underlying issue or condition.

54. Fatal fetal conditions are a narrow subset of diagnoses that are sufficiently severe that a pregnancy is unlikely to result in a surviving baby. These are conditions where the pregnancy is likely to end in miscarriage or stillbirth or, in the event of a live birth, the infant's survival will not be sustained—with or without medical support.

55. Fatal fetal conditions include diagnoses like anencephaly, where the brain and skull do not develop as expected; lethal skeletal dysplasias that constrict the chest and prevent fetal lung development; aneuploidies like classic Trisomy 18 and classic Trisomy 13, where the fetus has an additional copy of a particular chromosome; and bilateral renal agenesis, where the kidneys do not develop, the fetus cannot produce sufficient urine to support amniotic fluid levels, and this lack of fluid prevents the lungs from developing appropriately.

56. Some of these conditions are fairly common. Anencephaly occurs in 1 out of every 1,000 pregnancies,[6] and Trisomy 18 occurs in one out of every 2,500 pregnancies.[7]

57. It is impossible to identify every type of condition that makes sustained life outside the womb unlikely, and prognoses necessarily depend on the facts of a particular case. Physicians have the expertise to determine when conditions are likely fatal, as well as the training to support pregnant patients' decision-making in such circumstances, such as by providing them with accurate, unbiased information about the condition and the fetus's prognosis.

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[6] Cleveland Clinic, *Anencephaly*, *supra* note 2.

[7] Cleveland Clinic, *Edwards Syndrome (Trisomy 18)* (Dec. 13, 2021), https://my.clevelandclinic.org/health/diseases/22172-edwards-syndrome.

58. While all pregnancies come with increased risks to the pregnant person's health—such as hypertension, diabetes, pulmonary embolism, and hemorrhage—some fetal conditions increase the risks to the pregnant person even further. Some fetal conditions can increase the risks to a pregnant person's health such that, when combined with the patient's other comorbidities, a medical provider may determine that an abortion is necessary or recommended to prevent serious jeopardy to the pregnant person's health. Some fetal conditions present particularly acute risks to the pregnant person. For example, mirror syndrome is an emergent complication of pregnancy where the pregnant person and fetus both experience severe fluid retention that can lead to both fetal and maternal demise. A partial molar pregnancy is another example. Partial molar pregnancies can threaten a pregnant person's life due to unstoppable bleeding. Partial molar pregnancies can also become cancerous. However, not all health impacts from fetal conditions necessarily trigger the existing life-preserving care exception.

59. In some cases, only one fetus in a multiple gestation pregnancy (such as triplets) is affected by a fatal fetal condition. Continuing the pregnancy without intervention can pose risks to the other fetuses, including dramatically increasing the risk of preterm birth, complications after birth, and potentially morbidity and mortality. In such cases, a selective reduction procedure—an abortion of one fetus in a multiple gestation pregnancy—can ameliorate the risks to the other fetuses and significantly improve their outcomes.

60. Even if a fatal fetal condition does not pose acute health risks to the pregnant person or to a multifetal pregnancy, forcing a patient whose pregnancy has been diagnosed with a fatal condition to continue the pregnancy causes myriad other risks. Pregnancy is a natural but not always benign condition. Even a "typical" pregnancy comes with a host of temporary and long-term health consequences and carries risks of maternal morbidity and mortality. This is particularly

so in Oklahoma, where women die from causes related to or aggravated by pregnancy or its management at one of the highest rates in the nation.[8] Certain fatal fetal diagnoses, such as anencephaly or body stalk anomaly, can also complicate the labor and delivery process. Forcing a patient whose pregnancy has been diagnosed with a fatal condition to continue the pregnancy heightens these maternal health risks with no corresponding benefit to the fetus.

61. It is traumatizing to force patients to continue a pregnancy with a fatal fetal diagnosis until they either miscarry or give birth and potentially undergo the harrowing experience of watching their child live for only minutes while being helpless to stop it. Feelings of powerlessness and overwhelm come not just from the diagnosis, but also from having no meaningful choice about medical decisions or what happens to one's body. Patients must also contend with the day-to-day agony of being visibly pregnant, receiving comments and well-wishes from strangers, and potentially even being congratulated by well-meaning Labor & Delivery staff, all while knowing that the baby will not survive.

62. At the same time, the Bans prevent some families from having even a few hours with their baby, as inducing early delivery may be considered an abortion. Because the Bans create a risk of criminal prosecution for early inductions, patients and their families may be forced to continue the pregnancy to full term, even when that delay increases the risk of fetal demise or stillbirth and means that the baby will not be born alive. This cruelly deprives Oklahoma families of the opportunity to have any time—even a short time—with their living child.

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[8] *See* Okla. Maternal Health Task Force, Okla. State Dep't of Health, *Oklahoma Maternal Health Morbidity & Mortality Annual Report 2025*, at 17 (Nov. 2025), https://oklahoma.gov/content/dam/ok/en/health/health2/aem-documents/family-health/maternal-and-child-health/maternal-health-task-force/MMRC%20Annual%20Full%20Report%202025.pdf; Jillian Taylor, *Oklahoma Maternal Mortality Rate Dips Slightly, Remains Above National Average*, KGOU (Dec. 2, 2025), https://www.kgou.org/health/2025-12-02/oklahoma-maternal-mortality-rate-dips-slightly-remains-above-national-average.

63. Most fatal fetal conditions cannot be treated, either in utero or after birth. The medical standard of care for a patient who receives a fatal fetal diagnosis is to offer both expectant management (waiting with close monitoring) and abortion care, and to let the patient decide which course to take.

b. Abortion is essential healthcare, including for patients who receive fatal fetal diagnoses.

64. Legal abortion is among the safest, most common health services in the United States. Abortion is far safer than the alternative of carrying a pregnancy to term. The risk of death associated with childbirth is approximately 14 times higher than that associated with abortion, and every pregnancy-related complication is more common among those who undergo childbirth than those who have abortions.[9] This is especially true in Oklahoma. In the most recent data available from Oklahoma's Maternal Health Task Force, Oklahoma's maternal mortality rate of 29.0 maternal deaths per 100,000 live births exceeded the national average.[10]

65. The overwhelming majority of abortions in the United States are accomplished either through use of medications (medication abortion) or via an outpatient procedure (procedural abortion). Medication abortions are typically available earlier in pregnancy and, in the most commonly used protocol in the United States, involve the administration of two medications (mifepristone and misoprostol) to terminate the pregnancy and expel it via vaginal bleeding, akin to a spontaneous miscarriage. Procedural abortions are feasible throughout pregnancy and involve a two-step process where the medical provider first partially dilates the patient's cervix (using medications and/or mechanical or osmotic dilators) and then evacuates the uterus using suction

[9] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012).

[10] *See* Okla. Maternal Health Task Force, Okla. State Dep't of Health, *supra* note 8, at 17.

aspiration, instruments, or some combination of the two. Dilation is done either the same day or the day before evacuation. A procedural abortion typically takes around five minutes in the first trimester of pregnancy and ten to twenty minutes in the second trimester.[11]

66. The other medically proven abortion method is induction abortion, where a physician uses medication to induce labor and delivery of a nonviable fetus. Induction of labor accounts for only about 2% of second-trimester abortions nationally. Induction abortions are usually performed in a hospital or similar facility that has the capacity to closely monitor a patient and provide adequate pain management (e.g., intravenous pain medication or an epidural). Induction abortions can last anywhere from five hours to three days; are more expensive; and entail more pain, discomfort, medical risks, and recovery time for the patient—similar to giving birth—than procedural abortion.[12]

67. Because most fatal fetal conditions are diagnosed after the first trimester, abortion care in these circumstances is generally procedural abortion or induction abortion, rather than medication abortion. Some patients may prefer induction because it is similar to birth, and going through the delivery process and holding their baby, even if for a short time, may aid their grieving process. For other patients, procedural abortion is preferred because it is faster, safer, and entails shorter recovery time, and because having to deliver a stillborn baby or to watch their baby die in the minutes after birth can be extremely traumatizing. Patients should have the ability to choose not only whether to have an abortion, but also which abortion method is best for them.

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[11] *See* Nat'l Acads. of Sci., Eng'g, & Med., *The Safety and Quality of Abortion Care in the United States* 51–65 (2018).

[12] *See id.* at 5–8, 66–68.

c. The Bans prohibit pregnant people who receive a fatal fetal diagnosis from accessing abortion care.

68. Section 861 (the "Total Ban") went into effect in June 2022. It uses the term "abortion" only in its title,[13] but is understood to "criminalize the performance of certain abortions." *OCRJ I*, 2023 OK 24, ¶ 12, 526 P.3d at 1130–31. The term "abortion" is defined in various ways in Oklahoma law. For example, a section of the Public Health code defines "abortion" as:

> the use or prescription of any instrument, medicine, drug, or any other substance or device intentionally to terminate the pregnancy of a female known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, to remove an ectopic pregnancy, or to remove a dead unborn child who died as the result of a spontaneous miscarriage, accidental trauma, or a criminal assault on the pregnant female or her unborn child.

63 Okla. Stat. § 1-730.[14]

69. Violation of the Total Ban is a Class D1 felony. 21 Okla. Stat. § 861. A first offense is punishable by imprisonment for up to 5 years, with harsher penalties for subsequent violations. 21 Okla. Stat. § 20N(B)–(F).

70. The Total Ban has an exception for abortion "necessary to preserve [the pregnant person's] life." 21 Okla. Stat. § 861. The Oklahoma Supreme Court recognized that this exception

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[13] Section 861 prohibits administering to, prescribing for, or advising or procuring "any woman to take any medicine, drug or substance, or use[] or employ[] any instrument, or other means whatever, with intent thereby to procure the miscarriage of such woman, unless the same is necessary to preserve her life." 21 Okla. Stat. § 861. While § 861 does not define "miscarriage," the standard definition of "miscarriage" is "loss of a documented intrauterine pregnancy." *See, e.g.*, Am. Coll. of Obstetricians & Gynecologists, *reVITALize: Gynecology Data Definitions* (Nov. 19, 2018), https://www.acog.org/en/practice-management/health-it-and-clinical-informatics/revitalize-gynecology-data-definitions (defining "miscarriage/intrauterine pregnancy loss").

[14] The Oklahoma Attorney General has relied on definitions of "abortion" elsewhere in the Oklahoma statutory code in interpreting the Ban. *See* Okla. Att'y Gen., *Guidance for Oklahoma Physicians Following* Dobbs v. Jackson Women's Health Org., OCRJ v. Drummond, *and* OCRJ v. Oklahoma (Sept. 12, 2025), https://oklahoma.gov/content/dam/ok/en/oag/opinions/advisory-letters/Abortion%20Guidance%20to%20Oklahoma%20Physicians%20Final.pdf ("[I]f a physician acts 'with the intent to … remove an ectopic pregnancy,' it is not considered an abortion.").

permits abortion care protected by Oklahomans' right to life-preserving abortion, which the Court defined as:

> an inherent right to choose to terminate her pregnancy if at any point in the pregnancy, the woman's physician has determined to a reasonable degree of medical certainty or probability that the continuation of the pregnancy will endanger the woman's life due to the pregnancy itself or due to a medical condition that the woman is either currently suffering from or likely to suffer during the pregnancy.

OCRJ I, 2023 OK 24, ¶¶ 9, 16, 526 P.3d at 1130, 1132. The Court held that "[a]bsolute certainty is not required, however, mere possibility or speculation is insufficient." *Id.* ¶ 9, 526 P.3d at 1130. The Court recognized that doctors must have discretion when determining that abortion is a medically indicated course of treatment.

71. Section 1-745.5 (the "22-Week Ban"), on the other hand, bans abortion care after 22 weeks from the first day of the pregnant person's last menstrual period ("LMP"). Specifically, it prohibits "perform[ing] or induc[ing] or attempt[ing] to perform or induce an abortion . . . when it has been determined, by the physician performing or inducing or attempting to perform or induce the abortion or by another physician upon whose determination that physician relies, that the probable postfertilization age of the [pregnancy] is twenty (20) or more weeks." 63 Okla. Stat. § 1-745.5(A).[15] "Postfertilization age" is defined as "the [gestational age] as calculated from the fertilization of the human ovum." 63 Okla. Stat. § 1-745.2(3). In medical practice, the gestational age of a pregnancy is commonly measured starting from the first day of a person's last menstrual

[15] For purposes of the 22-Week Ban, Oklahoma defines "abortion" as "the use or prescription of any instrument, medicine, drug, or any other substance or device to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma, or a criminal assault on the pregnant woman or her unborn child, and which causes the premature termination of the pregnancy." 63 Okla. Stat. § 1-745.2(1).

period—which is typically two weeks prior to fertilization—rather than from fertilization. Thus, 63 Okla. Stat. § 1-745.5 operates as a ban on abortion after 22 weeks LMP.

72. Violation of the 22-Week Ban is a Class D2 felony. 63 Okla. Stat. § 1-745.7. A first offense is punishable by imprisonment for up to two years, with harsher penalties for subsequent violations. 21 Okla. Stat. § 20O(B)–(F).

73. The 22-Week Ban contains an exception where the pregnant person "has a condition which so complicates her medical condition as to necessitate the abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions." 63 Okla. Stat. § 1-745.5(A). Unlike the exception to the Total Ban, the 22-Week Ban's exception explicitly excludes "psychological or emotional conditions" and risks related to suicide or self-harm: the exception does not apply to a condition "if it is based on a claim or diagnosis that the woman will engage in conduct which she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function." *Id.* By contrast, the Total Ban does not limit its exception to only physical health impacts.

74. Some fatal fetal conditions may lead to fetal demise in utero and a spontaneous miscarriage; in other cases, a patient may seek abortion care. The medical treatment for miscarriage and abortion is identical. Efforts to distinguish "miscarriage management" from "elective abortion" do not accurately reflect the complexities of pregnancy or the difficult questions that patients confront when thinking about ending a pregnancy. Medical professionals understand that patients in any number of circumstances need abortions and that pregnant patients, in consultation with their healthcare providers, should be able to choose the method of abortion appropriate for their circumstances.

75. Under the Oklahoma Supreme Court's existing jurisprudence, in cases where a fatal fetal diagnosis threatens the pregnant person's life, they should be able to receive abortion care.[16] This case is about patients who receive a fatal fetal diagnosis that does not necessarily threaten their lives, a constituency whose constitutional rights continue to be violated. These patients face the inherent risks of continuing the pregnancy as well as potentially complicated deliveries without the possibility of bringing a child home from the hospital or, in some cases, spending any time with their living child. Yet Oklahoma cruelly forces these patients to continue to carry those pregnancies.

d. Prohibiting pregnant people who receive a fatal fetal diagnosis from accessing abortion care is inconsistent with Oklahoma's history and tradition and with other areas of Oklahoma law.

76. Prohibiting abortion care in cases of fatal fetal diagnoses is inconsistent with the history and tradition surrounding abortion in Oklahoma and across the country.

77. As the Oklahoma Supreme Court has noted, the text of the Total Ban includes an exception when abortion care is "necessary to preserve [the pregnant patient's] life." 21 Okla. Stat. § 861. This exception stretches back to the days of the Oklahoma Territory.[17] Most states' abortion laws enacted during this period had similar provisions; in fact, by 1900, only six states did not include such an exception in their abortion laws.[18]

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[16] Upon information and belief, while the Oklahoma Supreme Court's decision makes clear that neither imminent harm nor absolute certainty is required, the pervasive anti-abortion climate in the state has made doctors and hospital counsel wary of providing care unless they are certain that a particular patient meets the life-preserving care exception, even when this means waiting for the patient to develop an infection or other complications.

[17] *See* Okla. (Terr.) Stat. § 2187 (1890), *recodified at* Okla. (Terr.) Stat. § 2177 (1893), *recodified at* Okla. (Terr.) Stat. § 2268 (1903), *recodified at* Okla. Comp. Laws § 2370 (1909), *recodified at* Okla. Rev. Laws § 2436 (1910), *recodified at* Okla. Comp. Stat. Ann. § 1859 (1921), *recodified at* Okla. Stat. § 1834 (1931), *recodified at* 21 Okla. Stat. § 861 (1941).

[18] Kristin Luker, *Abortion and The Politics of Motherhood* 32 (1984); Loren G. Stern, *Abortion: Reform and the Law*, 59 J. Crim. L., Criminology, & Police Sci. 84, 86 & n.25 (1968); *see also* James Mohr, *Abortion in America: The Origins and Evolution of National Policy, 1800-1900*, at 24–43 (1979).

78. The Oklahoma Supreme Court has construed this "necessary to preserve . . . life" language to permit abortion care when "the continuation of the pregnancy will endanger the woman's life due to the pregnancy itself or due to a medical condition that the woman is either currently suffering from or likely to suffer from during the pregnancy." *OCRJ I*, 2023 OK 24, ¶ 9, 526 P.3d at 1130. Significantly, the Court has noted that this language does not "require[] one to wait until there is an actual medical emergency in order to receive treatment when the harmful condition is known or probable to occur in the future." *OCRJ I*, 2023 OK 24, ¶ 12, 526 P.3d at 1131.

79. This is consistent with historical meanings of "preserving the life." Nineteenth-century medical journals and gynecology textbooks indicate that "saving the life" of a pregnant person in abortion laws meant both "physical life in the narrow sense of the word (life or death)" as well as "the social, emotional, and intellectual life of a woman in the broad sense (style of life)."[19] Significantly, contemporaneous "[p]hysicians were willing to induce (and in their writing to advocate for inducing) abortions under both of these definitions of the term life."[20]

80. The historical indications for life-preserving abortion care "may be categorized as medical, psychiatric and fetal."[21] "When physicians discussed the legitimate grounds for abortion in the period between 1890 and 1950, they frequently assumed that abortions to preserve the health of the woman (including her mental health) were acceptable, as were abortions in cases of rape or

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[19] Luker, *supra* note 18, at 34.

[20] *Id.*; *see also* B. Jessie Hill, *Medical Authority and the Right to Life*, 104 Boston U. L. Rev. Online 67, 69–73 (2024); Sheldon Gelman, *"Life" and "Liberty": Their Original Meaning, Historical Antecedents, and Current Significance in the Debate Over Abortion Rights*, 78 Minn. L. Rev. 585, 623–24, 631 n.250 (1994) ("right to life" was historically understood to include the right to "a full or good or unimpeded 'life,'" which includes "indolency of body" or the right to be left alone).

[21] Herbert L. Packer & Ralph J. Gampell, *Therapeutic Abortion: A Problem in Law and Medicine*, 11 Stan. L. Rev. 417, 419 (1959).

incest or when there was a likelihood of what would later be called 'fetal deformity.'"[22] In 1900, J.A. Winfrey, a physician practicing in what is now Oklahoma, discussed as indications for abortion mental health conditions like "nervous diseases, not amenable to treatment, as puerperal mania, chorea and neuralgia."[23]

81. Even prominent anti-abortion activist Horatio Storer, who campaigned for laws like the Total Ban, "subscribed to a broad view of what 'saving the life' of a woman entailed . . . his list of indications for abortion includes other considerations besides strict preservation of maternal life, notably what would later be called health and 'fetal' indications."[24]

82. Though the ability to diagnose fetal conditions, as well as medical treatment generally, has improved since the nineteenth century, obstetrics textbooks from around the time of statehood recommended abortion when a fetus was diagnosed with a fatal condition (as opposed to treatable, non-fatal conditions like syphilis). For example, textbooks discussed fetal conditions where health risks to the pregnant person were "preventable, in great measure, by timely assistance of obstetrician."[25] Where "[t]he child generally dies either before, during, or shortly after delivery," "it is better not to risk mother by delay, for the sake of a child whose survival, at best, is extremely dubious."[26] "Since these statements prove that the foetus is lost in the majority of the cases and that it rarely remains alive, even if born living, we are justified in giving them the second place in our attentions, and regarding first of all the life and health of the mother, being careful at the same time not to attempt any dangerous and doubtful operation."[27]

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[22] Luker, *supra* note 18, at 46.

[23] J.A. Winfrey, *Abortion; Spontaneous and Induced*, 15 Tex. Med. J. 472, 474 (1900).

[24] Luker, *supra* note 18, at 34; *see* Horatio Storer, *On Criminal Abortion in America* 65 (1860).

[25] A.F.A King, *A Manual of Obstetrics* 291 (1886).

[26] *Id.*

[27] Franz Winckel, *A Text-book of Obstetrics* 425 (1890).

83. In Oklahoma specifically, "therapeutic abortion" has a long history. In 1917, an issue of the Journal of the Oklahoma State Medical Association identified it as a treatment "[that] should always be considered" in acute cases of tuberculosis in which the pregnant patient would, among other factors, be burdened by the care of other children or the subsequent care of the resulting child and where such burden could impact the patient's own health and recovery.[28] Throughout the early twentieth century, the Journal went on to repeatedly discuss therapeutic abortion for a range of conditions, including as a potential treatment for "pernicious nausea and vomiting" during pregnancy, as a potential requirement for the pregnancies of patients with Graves' disease, and as an "advisable" intervention where the pregnancy "ha[d] been subjected to therapeutic radiation, for it [was] generally admitted that serious radiation effects on the offspring will result in a high percentage of cases."[29]

84. Throughout the second half of the twentieth century, the Oklahoma State Medical Association ("OSMA") continued to highlight a variety of indications for therapeutic abortion, including in cases of "fetal deformity."[30]

85. In cases of rubella during pregnancy, twentieth century doctors, guided by the prevailing wisdom of the time that nearly a third of such pregnancies would result in "serious fetal

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[28] W.A. Fowler, M.D., *Pregnancy Among the Tuberculous*, 10 J. Okla. State Med. Ass'n 458, 459 (1917) (writing that therapeutic abortion was indicated where pregnant patient with tuberculosis was the caretaker for other children, the best treatment for tuberculosis could not be carried out, the patient could not be relied upon to prevent her newborn child from contracting the disease, or even where the patient "would be burdened with the subsequent care of the child to the point of seriously endangering her chances for recovery").

[29] Albert C. Hirshfield, B.Sc., M.D., *The Use of Corpus Luteum in Nausea and Vomiting of Pregnancy*, 14 J. Okla. State Med. Ass'n 26, 26–27 (1921); Charles W. Heitzman, M.D., *Goiter. Its Probable Cause. Comments on Treatment. Special Reference to Calcium Metabolism*, 17 J. Okla. State Med. Ass'n 169, 171–72 (1924); Wendell Long, M.D. *Surgery and Gynecology: Abstracts, Reviews and Comments from Leroy Long Clinic*, 29 J. Okla. State Med. Ass'n 152, 153 (1936).

[30] OSMA Journal, *Editorial: A Time to Speak Out*, 61 J. Okla. State Med. Ass'n 139, 139 (1968); House of Delegates Report of the President, *Section II: Abortion Survey*, 66 J. Okla. State Med. Ass'n 277, 283–84 (1973).

deformity," "believe[d] that abortions in the case of rubella were good medical practice."[31] This practice extended to Oklahoma doctors, who considered abortion when the pregnant patient had contracted rubella specifically due to the potential "congenital defects" of a fetus.[32]

86. Permitting abortion in cases of fatal fetal diagnoses is also consistent with other areas of Oklahoma law.

87. For example, Oklahoma law permits individuals to make end-of-life decisions based on their own beliefs, values, and judgment. This includes pregnant patients: pregnant individuals are entitled, just like non-pregnant individuals, to authorize that life-sustaining treatment and artificially administered hydration and nutrition be withheld or withdrawn, including "during a course of pregnancy." 63 Okla. Stat. § 3101.4.

88. Describing the purpose of the Oklahoma Advance Directive Act, the Oklahoma Legislature recognized that "decisions concerning one's medical treatment involve highly sensitive, personal issues that do not belong in court." 63 Okla. Stat. § 3101.2(A)(3). So too in cases of abortion care where there has been a fatal fetal diagnosis.

89. Oklahoma law expressly permits making end-of-life decisions for neonates, including withdrawing medical interventions after birth. *See* 63 Okla. Stat. § 3105.4(8). The law balances preventing abuses like the Baby Doe cases, in which medical intervention was deliberately withheld from neonates and infants with non-fatal conditions for eugenic reasons, with recognizing the reality that physicians and families are sometimes charged with making tremendously difficult decisions about how to contend with lethal infant health conditions, even soon after birth. In particular, the law does not require treatment that would "merely prolong

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[31] Luker, *supra* note 18, at 81.

[32] John C. Long & Ralph W. Danielson, *Cataract and Other Congenital Defects in Infants Following Rubella in the Mother* (abstract), 38 J. Okla. State Med. Ass'n 508 (1945).

dying," "not be effective in ameliorating or correcting all of the infant's life-threatening conditions," or "otherwise be futile in terms of the survival of the infant," or where "the provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane." 42 U.S.C § 5106g(a)(5); 63 Okla. Stat. § 3105.4(8).

90. Ultimately, Oklahoma's Bans force pregnant people and their families *into* these tremendously difficult situations against their will by categorically prohibiting them from obtaining abortion care in cases of fatal fetal diagnoses, unless the pregnant person's life is also threatened. This is inconsistent with Oklahoma law and history, and it is an affront to pregnant patients' inherent and substantive due process rights, including to preserve their lives and make autonomous medical decisions.

e. The Oklahoma Constitution protects pregnant people who receive a fatal fetal diagnosis.

91. The Oklahoma Constitution guarantees Oklahomans certain inherent rights, including to "life" and "liberty"; substantive due process rights; and equal protection rights. Okla. Const. art. II, §§ 2, 7. These rights are fundamental, and state laws affecting them are subject to the highest level of judicial scrutiny. *OCRJ III*, 2023 OK 111, ¶ 5, 543 P.3d at 114–15.

92. The Oklahoma Supreme Court has "emphasized the fundamental concept in American jurisprudence that every human being of adult years and sound mind has a right to determine what shall be done with his own body" and that it is the "prerogative of every patient to chart his own course and determine which direction he will take." *Scott v. Bradford*, 1979 OK 165, ¶ 14, 606 P.2d 554, 557; *see also In re K.K.B.*, 1980 OK 7, ¶ 8, 609 P.2d at 749 (recognizing that "liberty includes the freedom to decide about one's own health").

93. "Life" has always been understood to protect more than physiological survival.[33] Philosophers like John Locke in the natural rights tradition "consider[] life, not liberty, the most basic right. Moreover, this 'life' includes more than mere biological existence; it also encompasses physical integrity, 'health and indolency of body,' and even a minimum quality of life."[34] Thomas Hobbes also conceived of "life" as comprising biological existence, bodily integrity, and quality of life.[35] At the time of the Founding, this broad view of "life" was so widespread that it "seems inconceivable that anyone familiar with Locke, Hutcheson, and Blackstone would use 'life' to *limit* widely accepted notions of natural right."[36]

94. Given this expansive meaning of the constitutional right to life and the Oklahoma Supreme Court's explicit recognition of the right to medical decision-making, the Oklahoma Constitution prohibits the State from denying pregnant people who receive a fatal fetal diagnosis appropriate care.

95. Banning abortion in the context of fatal fetal diagnoses is a grave interference with pregnant patients' right to preserve their lives and to chart their life's course. Pregnant patients, together with their physicians, are best positioned to determine what is in the best interests of the patient and their fetus. Some patients may decide to continue the pregnancy, deliver, and grieve

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[33] *See, e.g.*, Joseph R. Grodin, *Rediscovering the State Constitutional Right to Happiness and Safety*, 25 Hastings Const. L.Q. 1, 3, 12–13 (1997) (discussing the natural rights origins of "life," "safety," and "happiness" in state inalienable rights clauses); Steven G. Calabresi & Sofia M. Vickery, *On Liberty and the Fourteenth Amendment: The Original Understanding of the Lockean Natural Rights Guarantees*, 93 Tex. L. Rev. 1299, 1305 (2015) (describing "typical Lockean Natural Rights Guarantee" as a "right to enjoy life, liberty, and property" and noting that some states "went even further and constitutionally protected the right to pursue and obtain happiness or safety").

[34] Gelman, *supra* note 20, at 588 ("if 'life' means what it did when the Framers drafted the Constitution, bodily integrity is part and parcel of the concept, and abortion, which implicates a woman's 'health' and 'body,' warrants constitutional protection as an aspect of 'life'").

[35] *Id.* at 617–18 (quoting Thomas Hobbes, *Leviathan* 211–12 (C.B. Macpherson ed., 1985) (1651).

[36] *Id.* at 651; *see also id.* at 661 ("The Americans' adherence to social contract theory, their familiarity with Locke, Hutcheson, and Blackstone, and, after the Stamp Act crisis, their revolutionary beliefs, all strongly suggest that all 'life, liberty, property' clauses protect 'life' in the fullest social contract sense of the term.").

that way. For other patients, doing that would impose severe physical and mental trauma, in addition to the health risks of pregnancy and childbirth.

f. Forcing a patient to continue carrying a pregnancy after receiving a fatal fetal diagnosis infringes on their fundamental rights and cannot survive strict scrutiny.

96. As applied to patients who receive a fatal fetal diagnosis, the Bans infringe on Oklahomans' inherent and substantive due process rights by prohibiting abortion entirely. As described above, fatal fetal conditions can create or exacerbate risks to maternal health, with no benefit to the fetus from continuing the pregnancy. Each of the patient plaintiffs in this case was prevented from accessing abortion and experienced dramatic impacts to her health because there is no exception in the Bans for fatal fetal diagnoses and her providers did not deem her "sick enough" to warrant life-preserving care.

97. As the Oklahoma Supreme Court has noted, the right to life-preserving abortion care is not limited to pregnant patients who are on death's door; indeed, the Court stated that "[w]e know of no other law that requires one to wait until there is an actual medical emergency in order to receive treatment when the harmful condition is known or probable to occur in the future." *OCRJ I*, 2023 OK 24, ¶ 12, 526 P.3d at 1131. But here, even when a fatal diagnosis has been made, and even when being forced to continue the pregnancy would have serious adverse impacts on the pregnant patient's physical and psychological health, the Bans block patients from accessing abortion care, in violation of their rights to life, liberty, and substantive due process.

98. The right to life includes concepts of autonomy, dignity, and self-determination, all of which are implicated here. The Bans force the State's anti-abortion fiat on pregnant Oklahomans who receive a fatal fetal diagnosis, preventing them from making and effectuating medical decisions that are best for themselves and their families.

99. Leading medical organizations—including OSMA, the AMA, ACOG, and SMFM—emphasized to the Oklahoma Supreme Court as amicus in *OCRJ I* that "state laws that criminalize and effectively ban abortion impermissibly interfere with individuals' fundamental right to bodily autonomy and integrity." *See* Brief for ACOG et al. as Amici Curiae Supporting Petitioners at 2, *OCRJ I*, 2023 OK 24, 526 P.3d 1123 (No. PR-120543). Abortion is fundamentally a "safe and essential component of reproductive health care." *Id.* Banning abortion causes "severe and detrimental physical and psychological health consequences" for pregnant Oklahomans. *Id.* at 8. This is true for patients who have received fatal fetal diagnoses, as it is for patients who seek abortions for other reasons: all pregnant people deserve the "ultimate control over their bodies and right to a meaningful choice when making medical decisions." *Id.* at 7.

100. State laws that infringe on Oklahomans' inherent rights to life and liberty and substantive due process are subject to strict scrutiny. Under the strict scrutiny standard articulated by the Court, "[t]he state may prevail only upon showing its subordinating interest is compelling and such interest must be narrowly tailored to avoid unnecessary abridgement of the right." *OCRJ I*, 2023 OK 24, ¶ 11, 526 P.3d at 1130 (citing *State ex rel. Okla. Bar Ass'n v. Porter*, 1988 OK 114, ¶¶ 24–25, 766 P.2d 958, 967–68).

101. "A mere showing of [a] state interest is insufficient; the interest must be paramount, of vital importance, and the burden is on the government to show its existence." *Id.* (citing *Porter*, 1988 OK 114, ¶ 25, 766 P.2d at 968). "The advance of the subordinating interest must outweigh the loss of protected rights and the government must employ means closely drawn to avoid unnecessary abridgement." *Id.*

102. The State has no interest in potential life when a physician has determined that a fetus has a fatal condition. As a result, banning access to abortion for patients who receive such

diagnoses cannot survive strict scrutiny or, indeed, any level of constitutional review. Even if the State somehow had a compelling interest in these patients' pregnancies, an outright ban on care could not possibly be narrowly tailored. And, even if rational basis review applied, there is no reason, rational or otherwise, to force these Oklahomans to continue their pregnancies.

103. Because these conditions are myriad and complex, physicians are best situated to determine when a fetal condition is fatal, just as they are best situated to determine when a patient's life is threatened. There are a host of factors that physicians consider when diagnosing a fetal condition and determining that a fetus is unlikely to survive. This can include genetic or structural conditions affecting the fetus in combination with conditions affecting the pregnant patient. Physicians exercise their medical judgment to determine what the chances of survival are so that the patient can decide whether to continue the pregnancy or seek an abortion. Open and honest communication and shared decision-making are the foundations of the physician-patient relationship, but the Bans undermine that relationship by substituting an absolutist, one-size-fits-all legislative judgment for the physician's individualized, patient-centered counseling. In so doing, the law conflicts with physicians' ethical obligations to their patients, and it undermines patients' bodily autonomy and self-determination in making medical decisions.

g. The Bans treat pregnant patients who receive fatal fetal diagnoses differently from other patients.

104. The Bans single out patients who receive a fatal fetal diagnosis for differential treatment in multiple ways. For example, by treating pregnant patients differently based on whether they seek to terminate pregnancies to preserve their lives or because of a fatal fetal condition, Oklahoma's Bans discriminate based on the exercise of the fundamental rights to life, liberty, and substantive due process.

105. The Bans also draw irrational lines between patients whose pregnancies have been diagnosed with fatal fetal conditions and patients seeking other healthcare, including, for example, patients seeking miscarriage management or patients who have chosen to withdraw life support while pregnant. In other contexts, Oklahoma does not ban standard of care treatment and thereby force patients into riskier and potentially less desirable alternatives. Particularly where, as here, the ultimate outcome will be the same, there can be no governmental interest in this disparate treatment.

106. The Bans further discriminate against pregnant patients with fatal fetal diagnoses on the basis of sex by treating them as less competent and capable of making healthcare decisions than other patients and by forcing them to remain pregnant based on sex stereotypes.

107. Singling out pregnant people alone and denying them the same right to make choices about their health and families perpetuates a "long and extensive history of sex discrimination." *Nev. Dep't of Hum. Res. v. Hibbs*, 538 U.S. 721, 730 (2003); *see also id.* at 736 (citing congressional findings that "[h]istorically, denial or curtailment of women's employment opportunities has been traceable directly to the pervasive presumption that women are mothers first"). At and around the time of statehood, courts regularly justified discriminatory treatment of women based on "her physical structure and a proper discharge of her maternal functions," which "having in view not merely her own health, but the well-being of the race—justify legislation to protect her." *Muller v. Oregon*, 208 U.S. 412, 422 (1908); *see also Bradwell v. Illinois*, 83 U.S. 130, 141 (1872) ("The paramount destiny and mission of woman are to fulfil[l] the noble and benign offices of wife and mother.").

108. That is Oklahoma's history as well. During debates at the Constitutional Convention on whether to include women's suffrage in the Constitution, even the speakers who

supported the right to vote relied heavily on stereotypes of women as mothers: for example, one speaker said that a mother "is the one that I think would help mould the destiny of this Nation; not through her boy, not through her child alone, but by putting her hand to the ballot."[37] Similarly, those who opposed the right to vote did so because "it brings about the disruption of the family" and distracts women who have "ample opportunities for the exercise of every motherly grace, and every womanly virtue" inside their homes.[38] One delegate joked that if women could vote, "you will come home to find the home once cheery, where the warm supper was on the table and the wife anxious for your return, and you will find a candidate for county commissioner has taken so much of her time that really it hadn't occurred to her that supper was a part of everyday life."[39]

109. When the State forces abortion-seekers to continue to carry fetuses that have no reasonable possibility of survival, it is imposing a prescriptive gender norm and continuing this long tradition of seeing all women as mothers who are expected to sacrifice their autonomy and rights—including their rights to life and liberty—whether they would choose to or not.

110. Both of the patient plaintiffs in this case suffered as a result of Oklahoma's typecasting, as the State sought to privilege its own views above plaintiffs' ability to make and effectuate autonomous medical decisions. This experience involved deeply personal considerations about what was best for themselves and their families, and decisions that implicated spiritual, moral, and existential questions central to individual identity and religious beliefs. Oklahoma recognizes that such decisions are complex and fraught in other contexts, such as in

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[37] Louise Boyd James, *The Woman Suffrage Issue in the Oklahoma Constitutional Convention*, 56 The Chronicles of Oklahoma 379, 386 (Winter 1978–79), https://gateway.okhistory.org/ark:/67531/metadc2099553/m2/1/high_res_d/1978-v56-n04_a01.pdf.

[38] *Id.* at 388.

[39] *Id.* at 391–92.

end-of-life care, but takes this agency away from pregnant people in the case of fatal fetal conditions.

111. This State-endorsed sex stereotyping has very real harms. It imposes the State's view on what to do in these difficult circumstances on individual patients, forcing Oklahomans like the patient plaintiffs to either continue to carry a pregnancy that is unlikely to result in a surviving baby or to leave their homes to obtain care elsewhere, if they can. This imposes serious consequences on patients—all of the physical symptoms related to pregnancy (let alone any heightened risks related to a fatal fetal condition), the mental health implications of forced continuation of their pregnancy, and the dignitary harms of taking away patients' ability to make and effectuate their own decisions in an extremely difficult time.

112. There can be no justification for such differential treatment. Pregnant patients who receive these diagnoses are just as capable of making these complex decisions as any other patient—and indeed, are far better situated than the State to determine how to weigh risks to their health with their other beliefs, identities, and values.

113. For all of the reasons described above, the Bans infringe on the rights of Oklahomans to access abortion care where they receive a fatal fetal diagnosis.

V. CLAIMS FOR RELIEF

First Claim for Relief
(Inherent Rights to Life and Liberty)

114. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1–113.

115. 21 Okla. Stat. § 861 and 63 Okla. Stat. § 1-745.5 as applied to Oklahomans with fatal fetal diagnoses violate Oklahomans' inherent rights to life and liberty, which include personal autonomy and bodily integrity, in violation of Oklahoma Constitution Article II, § 2.

Second Claim for Relief
(Substantive Due Process)

116. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1–113.

117. 21 Okla. Stat. § 861 and 63 Okla. Stat. § 1-745.5 as applied to Oklahomans with fatal fetal diagnoses violate Oklahomans' substantive due process protections in violation of Oklahoma Constitution Article II, § 7.

Third Claim for Relief
(Equal Protection – Fundamental Right)

118. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1–113.

119. "While the Oklahoma Constitution does not contain a provision identical to the equal protection clause in the federal constitution, it is well established that a like guarantee exists within our state constitution's due process clause," Okla. Const. art. II, § 7. *Callaway v. City of Edmond*, 1990 OK CR 25, ¶ 8, 791 P.2d 104, 106.

120. The Oklahoma Constitution protects the right to life-preserving abortion care and the right to abortion in cases of fatal fetal diagnoses based on the same constitutional principles. By treating pregnant patients differently based on whether they seek to terminate pregnancies to preserve their lives or because of a fatal fetal condition, 21 Okla. Stat. § 861 and 63 Okla. Stat. § 1-745.5 discriminate based on the exercise of a fundamental right.

121. Strict scrutiny applies to this distinction on the basis of a fundamental right, and the law as applied neither furthers a compelling governmental interest nor is narrowly tailored to do so. This distinction also lacks a rational relationship to protecting life, health, or any other legitimate state interest.

Fourth Claim for Relief
(Equal Protection – Rights of Pregnant Individuals Who Have Received a Fatal Fetal Diagnosis)

122. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1–113.

123. "While the Oklahoma Constitution does not contain a provision identical to the equal protection clause in the federal constitution, it is well established that a like guarantee exists within our state constitution's due process clause," Okla. Const. art. II, § 7. *Callaway*, 1990 OK CR 25, ¶ 8, 791 P.2d at 106.

124. Oklahoma does not prevent non-pregnant people from accessing reproductive healthcare that is within the standard of care, nor does it force them into one dispreferred medical decision that increases risks to their lives, health, and well-being.

125. To the extent 21 Okla. Stat. § 861 and 63 Okla. Stat. § 1-745.5 bar the provision of an abortion to a person whose pregnancy has been diagnosed with a fatal fetal condition, while allowing non-pregnant people to access medical treatment within the standard of care, they violate the rights to equal treatment of pregnant people who receive fatal fetal diagnoses.

126. Thus applied, the Bans lack a rational relationship to protecting life, health, or any other legitimate state interest.

Fifth Claim for Relief
(Equal Protection – Sex Discrimination)

127. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1–113.

128. "While the Oklahoma Constitution does not contain a provision identical to the equal protection clause in the federal constitution, it is well established that a like guarantee exists

within our state constitution's due process clause," Okla. Const. art. II, § 7. *Callaway*, 1990 OK CR 25, ¶ 8, 791 P.2d at 106.

129. 21 Okla. Stat. § 861 and 63 Okla. Stat. § 1-745.5 as applied to Oklahomans with fatal fetal diagnoses violate Oklahomans' state constitutional equal protection rights under Article II, § 7 by subjecting them to discrimination on the basis of sex.

130. Application of the Bans to patients with fatal fetal diagnoses denies equal protection of laws because it singles out women and people capable of becoming pregnant, and it perpetuates sex-based stereotypes that pregnancy is the ideal role for women. In doing so, the Bans devalue the lives of women and people capable of becoming pregnant and promote stereotypes that are used to justify the forced continuation of pregnancy, even if those pregnancies are unlikely to result in survival until or after birth.

131. Laws that distinguish between pregnant and non-pregnant individuals in this manner are subject to intermediate scrutiny and can be upheld only if substantially related to an important or substantial state interest. But there is no important or substantial state interest here, as prohibiting abortion care in these circumstances undermines any interest in health and safety, and there can be no interest in potential life where such a pregnancy is unlikely to result in survival.

Sixth Claim for Relief
(Declaratory Judgment – Unconstitutional and Void)

132. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1–113.

133. Because 21 Okla. Stat. § 861 and 63 Okla. Stat. § 1-745.5 violate the Oklahoma Constitution and a declaratory judgment would terminate the controversy giving rise to this proceeding, Plaintiffs request a declaration from this Court stating that the Bans are

unconstitutional and void as applied to Oklahomans who have received a fatal fetal diagnosis. 12 Okla. Stat. § 1651.

Seventh Claim for Relief
(Permanent Injunction – Unconstitutional and Void)

134. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1–113.

135. Because 21 Okla. Stat. § 861 and 63 Okla. Stat. § 1-745.5 violate the Oklahoma Constitution, warranting a declaratory judgment stating that the Bans are unconstitutional and void as applied to Oklahomans who have received a fatal fetal diagnosis, Defendants should be permanently enjoined from enforcing these applications.

VI. PRAYERS FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that this Court:

1. Issue a declaratory judgment that 21 Okla. Stat. § 861 and 63 Okla. Stat. § 1-745.5 as applied to pregnant Oklahomans who receive a fatal fetal diagnosis violate the Oklahoma Constitution and are void and of no effect;
2. Issue permanent injunctive relief, without bond, restraining Defendants, their employees, agents, and successors in office, and all others who are in concert or participation with them, from enforcing 21 Okla. Stat. § 861 and 63 Okla. Stat. § 1-745.5 as applied to pregnant Oklahomans who receive a fatal fetal diagnosis; and
3. Grant such other and further relief as the Court may deem just and proper, including reasonable attorney's fees and costs.

Dated: September 16, 2026

Respectfully Submitted,

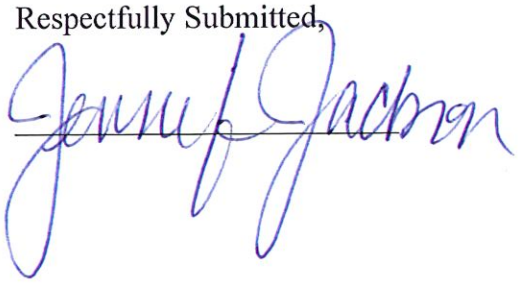

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Exhibit A

Oklahoma Statutes Annotated
Title 21. Crimes and Punishments
Part IV. Crimes Against Public Decency and Morality
Chapter 32. Abortion and Concealing Death of Children (Refs & Annos)

21 Okl.St.Ann. § 861

§ 861. Procuring an abortion

Effective: January 1, 2026
Currentness

Every person who administers to any woman, or who prescribes for any woman, or advises or procures any woman to take any medicine, drug or substance, or uses or employs any instrument, or other means whatever, with intent thereby to procure the miscarriage of such woman, unless the same is necessary to preserve her life, shall be guilty of a Class D1 felony offense punishable by imprisonment as provided for in subsections B through F of Section 20N of this title.

Credits

R.L.1910, § 2436; Laws 1961, p. 230, § 1; Laws 1997, c. 133, § 257, eff. July 1, 1999; Laws 1999, 1st Ex.Sess., c. 5, § 161, eff. July 1, 1999; Laws 2025, c. 486, § 388, eff. Jan. 1, 2026.

Editors' Notes

VALIDITY

<Section held unconstitutional by *Henrie v. Derryberry*, N.D.Okla.1973, 358 F.Supp. 719. See Notes of Decisions, post. But see, Dobbs. v. Jackson Women's Health Org., 142 S.Ct. 2228.>

Notes of Decisions (10)

21 Okl. St. Ann. § 861, OK ST T. 21 § 861
Current with legislation of the Second Regular Session of the 60th Legislature (2026) effective as of November 1, 2026. Some sections may be more current, see credits for details.

End of Document

Exhibit B

Oklahoma Statutes Annotated
Title 63. Public Health and Safety (Refs & Annos)
Chapter 1. Public Health Code
Article 7. Hospitals and Related Institutions
C-9. Pain-Capable Unborn Child Protection Act

63 Okl.St.Ann. § 1-745.5

§ 1-745.5. Abortions prohibited when probable postfertilization age of unborn child is 20 or more weeks--Exceptions--Procedure for abortion

Currentness

A. No person shall perform or induce or attempt to perform or induce an abortion upon a woman when it has been determined, by the physician performing or inducing or attempting to perform or induce the abortion or by another physician upon whose determination that physician relies, that the probable postfertilization age of the woman's unborn child is twenty (20) or more weeks, unless, in reasonable medical judgment, she has a condition which so complicates her medical condition as to necessitate the abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions. No such condition shall be deemed to exist if it is based on a claim or diagnosis that the woman will engage in conduct which she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function.

B. When an abortion upon a woman whose unborn child has been determined to have a probable postfertilization age of twenty (20) or more weeks is not prohibited by this section, the physician shall terminate the pregnancy in the manner which, in reasonable medical judgment, provides the best opportunity for the unborn child to survive, unless, in reasonable medical judgment, termination of the pregnancy in that manner would pose a greater risk either of the death of the pregnant woman or of the substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions, of the woman than would other available methods. No such greater risk shall be deemed to exist if it is based on a claim or diagnosis that the woman will engage in conduct which she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function.

Credits
Laws 2011, c. 89, § 5, eff. Nov. 1, 2011.

Notes of Decisions (13)

63 Okl. St. Ann. § 1-745.5, OK ST T. 63 § 1-745.5
Current with legislation of the Second Regular Session of the 60th Legislature (2026) effective as of November 1, 2026. Some sections may be more current, see credits for details.

End of Document

VERIFICATION

The undersigned Plaintiff has read the contents of the Verified Petition. The undersigned hereby verifies, under penalty of perjury, that the contents of the Verified Petition are true and correct to the best of her present knowledge.

Magon Hoffman

Sworn to me this 4 day

of September, 2026

ALEX SANCHEZ
NOTARY
25005507
EXP. 05/08/29
PUBLIC
STATE OF OKLAHOMA

NOTARY PUBLIC

VERIFICATION

The undersigned Plaintiff has read the contents of the Verified Petition. The undersigned hereby verifies, under penalty of perjury, that the contents of the Verified Petition are true and correct to the best of her present knowledge.

Sheena Hamlin

Sworn to me this 13 day

of September, 2026

ABIGAIL BURKE NOTARY PUBLIC # 21008871 EXP. 06/29/29 STATE OF OKLAHOMA

NOTARY PUBLIC

VERIFICATION

The undersigned Plaintiff has read the contents of the Verified Petition. The undersigned hereby verifies, under penalty of perjury, that the contents of the Verified Petition are true and correct to the best of her present knowledge.

D'Marria Monday

D'Marria Monday

Board Member

Oklahoma Call for Reproductive Justice

Sworn to me this 15 day

of September, 2026

DJ CARR
Notary Public - State of Oklahoma
COMMISSION #05003197
Expires 03/31/2029

NOTARY PUBLIC

VERIFICATION

The undersigned Plaintiff has read the contents of the Verified Petition. The undersigned hereby verifies, under penalty of perjury, that the contents of the Verified Petition are true and correct to the best of her present knowledge.

Elizabeth Pinard, M.D.

Sworn to me this 11 day

of September, 2026

SHELLEY NIXON
Notary Public - State of Oklahoma
Commission Number 13006319
My Commission Expires Jul 11, 2029

NOTARY PUBLIC

VERIFICATION

The undersigned Plaintiff has read the contents of the Verified Petition. The undersigned hereby verifies, under penalty of perjury, that the contents of the Verified Petition are true and correct to the best of her present knowledge.

Sarah Mashburn, M.D.

Sworn to me this 15day

of September, 2026

SHELLEY NIXON
Notary Public - State of Oklahoma
Commission Number 13006319
My Commission Expires Jul 11, 2029

NOTARY PUBLIC