STATE OF MICHIGAN
IN THE COURT OF CLAIMS

PLANNED PARENTHOOD OF MICHIGAN, on behalf of itself, its physicians and staff, and its patients; and **SARAH WALLETT, M.D., M.P.H., FACOG**, on her own behalf and on behalf of her patients,

Plaintiffs,

v

ATTORNEY GENERAL OF THE STATE OF MICHIGAN, in her official capacity,

Defendant,

and

MICHIGAN HOUSE OF REPRESENTATIVES and **MICHIGAN SENATE**,

Intervening Defendants.
_____ /

Case No. 22-000044-MM

Hon. Elizabeth L. Gleicher

BRIEF IN SUPPORT OF PLAINTIFFS' JUNE 29, 2022 MOTION FOR SUMMARY DISPOSITION

ORAL ARGUMENT REQUESTED

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INTRODUCTION

As anticipated as a real and imminent risk in Plaintiffs' pleadings, the United States Supreme Court recently decided *Dobbs v Jackson Women's Health Organization*, ___ US ___; ___ S Ct ___; ___ L Ed 2d ___; 2022 WL 2276808, at *43 (US, June 24, 2022) (Docket No. 13-1932), overruling *Roe v Wade*, 410 US 113; 93 S Ct 705; 35 L Ed 2d 147 (1973), and *Planned Parenthood of Southeastern Pennyslvania v Casey*, 505 US 833; 112 S Ct 279; 1120 L Ed 2d 674 (1992), and eliminating the federal constitutional right to abortion that Michiganders have relied upon for almost five decades. It is only this Court's May 17, 2022 preliminary-injunction order, preserving the decades-long status quo until a final determination of Plaintiffs' and their patients' rights under the 1963 Michigan Constitution are ruled upon, that has preserved access to abortion in Michigan and allowed Plaintiffs to continue providing care and treatment to their patients.

Plaintiffs Planned Parenthood of Michigan (PPMI) and Sarah Wallett, M.D., M.P.H., FACOG, now move for summary disposition under MCR 2.116(C)(10). A 1931 Michigan statute, MCL 750.14 (the Criminal Abortion Ban), bans abortion, even in cases of rape, incest, or grave threats to the pregnant person's health. Under this statute, providing or procuring an abortion at any point in pregnancy is punishable as a felony, unless the abortion is necessary to save the pregnant person's life. As a matter of law, the Criminal Abortion Ban violates the rights to bodily integrity, equal protection, liberty, and privacy as guaranteed by the Michigan Constitution and the Elliott-Larsen Civil Rights Act (ELCRA). The statute is also void for vagueness.

As set forth below, summary disposition is appropriate at this time, as there is no genuine dispute over material facts that precludes this Court from declaring, as a matter of law, that the Criminal Abortion Ban is unconstitutional. To protect Plaintiffs and their patients from the profound and irreparable harm that the Criminal Abortion Ban would inflict, this Court should declare that the Michigan Constitution provides a right to abortion before viability, and after

viability to preserve the patient's life or health, and enter a permanent injunction blocking enforcement of MCL 750.14 and any other statute that conflicts with this constitutional right.

BACKGROUND

I. The Criminal Abortion Ban

Michigan's Criminal Abortion Ban provides:

> Any person who shall willfully administer to any pregnant woman any medicine, drug, substance or thing whatever, or shall employ any instrument or other means whatever, with intent thereby to procure the miscarriage of any such woman, unless the same shall have been necessary to preserve the life of such woman, shall be guilty of a felony, and in case the death of such pregnant woman be thereby produced, the offense shall be deemed manslaughter.
>
> In any prosecution under this section, it shall not be necessary for the prosecution to prove that no such necessity existed. [MCL 750.14.]

A violation of the Criminal Abortion Ban constitutes an unclassified felony, punishable by up to four years' imprisonment, a fine of up to $5,000, or both. MCL 750.503. Physicians convicted of violating the Criminal Abortion Ban may also face administrative penalties from the Michigan Department of Licensing and Regulatory Affairs (LARA), including permanent license revocation. MCL 333.16221(b)(v); MCL 333.16226(1). Michigan-licensed health care facilities that employ physicians who violate the Criminal Abortion Ban may face possible penalties as well, including criminal prosecution, see MCL 750.10; MCL 333.20199(1), license revocation through administrative enforcement by LARA, see MCL 333.20165; MCL 333.20168(1), or actions to enjoin operation of their licensed facility, MCL 333.20177. The Criminal Abortion Ban has a six-year statute of limitations. MCL 767.24(10).

In 1973, in *Roe v Wade*, the United States Supreme Court held that a Texas statute, making it a crime to "procure an abortion," except for the purpose of saving the pregnant person's life, violated the Fourteenth Amendment to the United States Constitution, 410 US at 117–118. The

Court held that the Fourteenth Amendment right to privacy barred a state from banning abortion before viability, or after viability where necessary to preserve a woman's life or health. *Id.* at 164–165.

Immediately after *Roe* was decided, in *People v Bricker*, 389 Mich 524; 208 NW2d 172 (1973), the Michigan Supreme Court relied solely on the federal constitution to find the Criminal Abortion Ban "cannot stand as relating to abortions" protected under *Roe*. *Bricker,* 389 Mich at 527. The Court did not separately address the Criminal Abortion Ban's legality as a matter of Michigan constitutional law. Instead, the Michigan Supreme Court construed the statute as not applying to abortions that were constitutionally protected by *Roe*. See *Bricker*, 389 Mich at 529–530, 531. Accordingly, under *Bricker*, the Criminal Abortion Ban does not prohibit pre-viability abortions performed by a physician, or post-viability abortions necessary to preserve the pregnant person's life or health. This construction has been relied upon and has guided physicians like Dr. Wallett and health care providers like PPMI in providing abortion in Michigan for almost five decades; their patients have also relied on the availability of this abortion care in Michigan.

However, the Michigan Supreme Court has never addressed the constitutionality of the Criminal Abortion Ban as a matter of Michigan law. While the Michigan Court of Appeals held in *Mahaffey v Attorney General*, 222 Mich App 325; 564 NW2d 104 (1997), that "the right of privacy under the Michigan Constitution does not include the right to abortion," *id.* at 345, *Mahaffey* did not consider the legality of the Criminal Abortion Ban independent of a *Roe* construction, nor did the Court consider or rule upon challenges based upon other state constitutional claims such as those Plaintiffs raise in this case.

As anticipated, the *Bricker* construction has now been undermined by the United States Supreme Court's decision in *Dobbs*, which overruled *Roe*—on which the *Bricker* construction is

founded. See *Dobbs*, 2022 WL 2276808, at *43. With its decision, the United States Supreme Court has eliminated the federal constitutional right to abortion upon which Michigan law has relied and Michiganders have depended for almost five decades.

However, while the United States Supreme Court's decision is binding for purposes of applying federal constitutional law, only Michigan courts can determine the meaning and proper application of Michigan law, particularly for purposes of interpreting its Constitution, which includes the authority to interpret it more expansively than its federal counterpart. As the Michigan Supreme Court has recognized, "[i]n the case of a divided United States Supreme Court decision, [it] may in some cases find more persuasive, and choose to rely upon, the reasoning of the dissenting justices of that Court, and not the majority, for purposes of interpreting our own Michigan Constitution." *People v Bullock*, 440 Mich 15, 27–28, 485 NW2d 866 (1992). As set forth below, "our own Michigan Constitution" supports a ruling here that there is a fundamental right to abortion in this state.

II. The Plaintiffs

A. Planned Parenthood of Michigan

PPMI is a not-for-profit corporation that currently operates 14 health centers across Michigan, in Ann Arbor, Detroit, Ferndale, Flint, Grand Rapids, Jackson, Kalamazoo, Lansing, Livonia, Marquette, Traverse City, Petoskey, and Warren. Affidavit of Sarah Wallett, M.D., M.P.H., FACOG, in Support of Plaintiffs' April 7, 2022 Motion for Preliminary Injunction (Wallett Aff) ¶ 11 (Attached hereto as Ex. 1). PPMI or its predecessors have been operating in Michigan since at least 1922. *Id*. ¶ 11.

PPMI's health centers provide a wide range of reproductive and sexual health services to patients, including abortion. *Id*. ¶ 12. All 14 of PPMI's health centers provide medication abortion

up to 11 weeks in pregnancy, as measured from the first day of the pregnant person's last menstrual period (LMP), where the patient takes a set of pills to end their pregnancy. *Id.* ¶¶ 13, 46. PPMI's Ann Arbor East and Kalamazoo health centers also provide procedural abortion, where a physician uses suction and sometimes instruments to empty the patient's uterus, up to 19 weeks, 6 days LMP, and its Flint health center provides procedural abortion up to 16 weeks, 6 days LMP. *Id.* ¶ 13. Each of these three health centers is licensed as a Freestanding Outpatient Surgical Facility by LARA. *Id.* ¶ 13. Other physicians and hospitals also provide medication abortion and procedural abortion in Michigan to later points in pregnancy. *Id.* ¶ 11.[1]

In 2020, the most recent year for which statistics were available at the time of filing the motion for a preliminary injunction, 29,669 abortions were performed in Michigan. *Id.* ¶ 42. In Fiscal Year 2020, PPMI provided 8,448 abortions. Of those, 6,626 were medication abortions, and 1,822 were procedural abortions. *Id.* ¶ 13. Between July 2020 and June 2021, PPMI saw 615 abortion patients who traveled to its health centers from other states—7% of the total number of abortion patients seen in that time period. *Id.* ¶ 17. By comparison, in that same time frame, 3% of the patients PPMI saw for *all* health care services (including abortion) came from out of state. *Id.* ¶ 17. At PPMI, between July 2020 and June 2021, 27% of abortion patients had incomes below 101% of the federal poverty level, and an additional 22% had incomes between 100% and 200% of the federal poverty level.[2] *Id.* ¶ 51.

[1] Northland Family Planning Centers, located in Sterling Heights, Westland, and Southfield, Michigan, provide procedural abortions up to 24 weeks LMP. Northland Family Planning Centers, *Second Trimester Abortion (15-24 weeks)* <https://northlandfamilyplanning.com/second-trimester> (accessed June 28, 2022).

[2] In 2020, 200% of the federal poverty level was $25,520 annually for a household of one, and $34,480 annually for a household composed of one parent and one child. *Id.* ¶ 51.

PPMI employs full-time physicians and part-time physicians, as well as physicians who are contracted through arrangements with teaching hospitals and universities. *Id.* ¶ 15. At its health centers, PPMI trains medical students, residents in obstetrics/gynecology (OB/GYN), family medicine residents, family medicine fellows, and OB/GYN fellows to provide abortion and other health care. *Id.* ¶ 9.

By its terms, the Criminal Abortion Ban outlaws the abortions that PPMI provides. MCL 750.14. PPMI faces possible felony criminal prosecution and licensure penalties for violating the Criminal Abortion Ban, as well as possible actions to enjoin operation of its licensed health centers. See MCL 750.14; MCL 333.20199(1); MCL 333.20165; MCL 333.20168(1); MCL 333.20177; see also MCL 750.10; MCL 333.20109, citing MCL 333.1106.

PPMI intends to continue to provide abortions to people in Michigan as long as the Criminal Abortion Ban is enjoined. Wallett Aff ¶¶ 88, 91. If the Criminal Abortion Ban is enforced according to its terms, PPMI will be forced to stop providing abortions at its health centers in Michigan. *Id.* ¶¶ 3, 13, 73, 75, 88, 91.

B. Sarah Wallett, M.D., M.P.H., FACOG

Dr. Wallett is a board-certified medical doctor specializing in OB/GYN and is licensed in Michigan. *Id.* ¶ 1. Since 2019, she has been the Chief Medical Officer of PPMI. *Id.* ¶ 9. Dr. Wallett is also an adjunct clinical assistant professor at the University of Michigan Medical School. *Id.*

At PPMI, Dr. Wallett provides abortions to people from Michigan as well as people who travel to Michigan from other states. *Id*. ¶ 2.

By its terms, the Criminal Abortion Ban outlaws the abortions that Dr. Wallett provides at PPMI. See MCL 750.14. Dr. Wallett thus faces possible felony criminal prosecution and potential licensure penalties for violating the Criminal Abortion Ban. See Wallett Aff ¶¶ 1, 3–4, 73, 75.

Dr. Wallett intends to continue to provide abortions to people in Michigan as long as the Criminal Abortion Ban is enjoined. *Id.* ¶¶ 88, 91. If the Criminal Abortion Ban is enforced according to its terms, Dr. Wallett will be forced to stop providing abortions in Michigan. *Id.* ¶¶ 3, 13, 73, 75, 88, 91.

III. This Litigation

In April 2022, Plaintiffs brought this lawsuit on behalf of themselves and their patients against the Michigan Attorney General in her official capacity, as the top law enforcement official in the state. See MCL 14.28–14.30; Const 1963, art 5, §§ 1, 3. On June 6, 2022, the Michigan House of Representatives and Michigan Senate (Intervenors) moved unopposed to intervene as defendants. The Court granted intervention on June 17, 2022. Plaintiffs now seek a declaratory judgment that the Criminal Abortion Ban is unconstitutional as a matter of Michigan law and seek a permanent injunction blocking the Ban's enforcement based solely on the protections in the Michigan Constitution.

Plaintiffs previously sought a preliminary injunction to preserve the status quo pending final resolution of their claims, supported by affidavit from Dr. Wallett detailing the impending irreparable harm that Planned Parenthood and its patients would suffer absent an injunction. This Court entered a preliminary injunction on May 17, 2022. The Court's opinion explained that the Michigan Constitution applied "more expansively" and "in a manner more protective of civil liberties" than the federal constitution in certain circumstances. Op, pp 13–14. The Court recognized that it was not "constrained to adopt the United States' Supreme Court's analysis of the constitutionality of abortion under the United States Constitution but must instead focus its inquiry on the rights and guarantees conferred by our Constitution." Op, p 15. The Court further concluded that the Michigan Constitution's due-process right to bodily integrity extended to the

right to abortion: "If a woman's right to bodily integrity is to have any real meaning, it must incorporate her right to make decisions about the health events most likely to change the course of her life: pregnancy and childbirth." Op, pp 22–23. The Court therefore found "a substantial likelihood that [the Criminal Abortion Ban] violates the Due Process Clause of Michigan's Constitution." Op, pp 24–25. Weighing the other preliminary injunction factors, the Court concluded that preliminary injunctive relief was warranted so that the risk of prosecution under the Criminal Abortion Ban would not chill Plaintiffs' provision of abortion in Michigan—a dramatic reduction in access which in turn would cause irreparable harm to Plaintiffs and their patients. Op, pp 25–26.

The Court's findings and conclusions in its preliminary injunction ruling should be made permanent. There is no genuine issue as to any material fact: the Criminal Abortion Ban makes it a felony to provide abortion under virtually all circumstances, MCL 750.14, and will therefore force Plaintiffs to stop providing abortion to their patients, Wallett Aff ¶¶ 2, 3, 13, 71, 73, 75, 88. As a matter of law, banning abortion violates the Michigan Constitution's rights to bodily integrity, equal protection, liberty, and privacy, as well as the Elliott-Larsen Civil Rights Act. The Criminal Abortion Ban is also unconstitutionally vague. Plaintiffs accordingly move for summary disposition under MCR 2.116(C)(10) and ask the Court to enter a declaratory judgment and a permanent injunction against enforcement of the Criminal Abortion Ban and any other Michigan statute or regulation that prohibits abortion.

STATEMENT OF FACTS

I. Facts Relating to Pregnancy

The decision to become or remain pregnant is one of the most personal and consequential a person will make in their lifetime. Wallett Aff ¶ 41; see also *id.* ¶¶ 19–40. People experience

their pregnancies in a range of different ways. *Id.* ¶ 20. While pregnancy can be a celebratory and joyful event for many, even an uncomplicated pregnancy challenges a person's entire physiology. *Id.*; see also *id.* ¶¶ 23–28, 31–32, 39. Pregnancy can also be a period of physical and personal discomfort, *id.* ¶ 20; some pregnant people experience significant mental health challenges, *id.* ¶¶ 20, 31, 39.

A typical pregnancy generally lasts roughly 40 weeks LMP. *Id.* ¶ 23. Every pregnancy necessarily involves significant physical change. *Id.* ¶ 23.

Pregnancy also carries significant medical risk. *Id.* ¶¶ 21–31. Women of color, and Black women in particular, face heightened risks of maternal mortality and pregnancy-related complications compared to non-Hispanic white women. *Id.* ¶ 22; see also *id.* ¶ 82. This disparity has been exacerbated in the past year. *Id.* Mental health conditions may emerge for the first time or recur during pregnancy or in the postpartum period. *Id.* ¶ 31. Pregnant people with a prior history of mental health conditions face a heightened risk of postpartum mental illness. *Id.* ¶ 13. Every pregnancy-related complication is more common among women having live births than among those having abortions. *Id.* ¶ 42.

Separate from pregnancy, childbirth itself is a significant medical event. *Id.* ¶ 32; see also *id.* ¶ 42. Even a normal pregnancy can suddenly become life-threatening during labor and delivery. *Id.* ¶ 32. People who undergo labor and delivery can experience unexpected adverse events such as transfusion, perineal laceration, ruptured uterus, and unexpected hysterectomy. *Id.* ¶ 33. A substantial proportion of deliveries occurs by Cesarean section (C-section), an open abdominal surgery requiring hospitalization for at least a few days. See *id.* ¶ 34. While common, C-sections carry risks of hemorrhage, infection, and injury to internal organs. *Id.* ¶ 34.

A woman's risk of death associated with childbirth, specifically, is more than 12 times

higher than that associated with abortion, and the total risk of maternal mortality is 34 times higher than the risk of death associated with abortion. *Id.* ¶ 42.

Pregnant people may also face an increased risk of intimate partner violence. *Id.* ¶ 38. Women who have experienced intimate partner violence and who give birth after being unable to access a desired abortion will, in many cases, face increased difficulty escaping that relationship. *Id.*; see also *id.* ¶ 53.

Pregnancy, childbirth, and raising a child can have long-term impacts on a person's financial security, particularly if they are already facing an array of economic hardships. *Id.* ¶¶ 37, 80 & n 77, 81; see also *id.* ¶ 52. The financial burdens of pregnancy and childbirth weigh even more heavily on people without insurance, who are disproportionately people of color, and on people with unintended pregnancies, who may not have sufficient savings to cover pregnancy-related expenses. *Id.* ¶ 37. Almost half of the pregnancies in the U.S. are unintended, and people of color and people with low incomes experience unintended pregnancy at a disproportionately higher rate, in large part due to systemic barriers to contraceptive access. *Id.* ¶ 37.

Many people decide that adding a child to their family is well worth all of these risks and consequences. *Id.* ¶ 41. But if abortion becomes unavailable in Michigan, thousands of pregnant people in this state will be forced to assume those risks involuntarily. *Id.*; see also *id.* ¶¶ 76–77.

II. Facts Relating to Abortion

Abortion is one of the safest and most common medical services performed in the United States today. *Id.* ¶ 42. Indeed, legal abortion carries far fewer risks than childbirth. *Id.* ¶ 42; compare *id.* ¶¶ 19–41, with *id.* ¶¶ 43–58, 80–81.

Of the 29,669 induced abortions performed in Michigan in 2020, the Michigan Department of Health reports just seven immediate complications.[3] The average three-year rate of immediate abortion complications between 2017 and 2019 was 3.5 per 10,000 induced abortions: just 0.035%.[4]

Approximately one in four women in this country will have an abortion by age forty-five. *Id.* ¶ 42.

There are two general types of abortion: medication abortion and procedural abortion. *Id.* ¶ 43. For medication abortion, patients take a regimen of two prescription drugs approved by the U.S. Food and Drug Administration (FDA). *Id.* ¶ 44. Together, the medications cause the pregnancy to pass in a process similar to miscarriage. *Id.* ¶ 44. This medication abortion regimen is widely used to terminate pregnancies through 11 weeks LMP. After 11 weeks LMP, only procedural abortion is generally available. *Id.* ¶ 45.

For procedural abortion, a clinician uses instruments and/or medication to widen the patient's cervical opening and to evacuate the contents of the uterus. *Id.* ¶ 46. Procedural abortion is a straightforward and brief procedure. *Id.* It is almost always performed in an outpatient setting and may at times involve local anesthesia or conscious sedation to make the patient more comfortable. *Id.* Although procedural abortion is sometimes referred to as "surgical abortion," it is not what is commonly understood to be surgery, as it involves no incisions, no need for general anesthesia, and no need for a sterile field. *Id.*

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[3] Mich Dep't of Health, Div for Vital Records & Health Stats, *Table 22, Number, Percent and Rate of Reported Induced Abortions with Any Mention of Immediate Complication by Type of Immediate Complication, Michigan Occurrences, 2020* <https://www.mdch.state.mi.us/osr/abortion/Tab_13.asp> (accessed April 4, 2022).

[4] *Id.*

Up to approximately 14 weeks LMP, procedural abortion relies on the aspiration technique. *Id.* ¶ 47. After that point, procedural abortion involves the dilation and evacuation technique. *Id.* Starting around 18 to 20 weeks LMP, an additional procedure may be performed to ensure that the patient's cervix is adequately dilated for the procedural abortion. *Id.* This may occur on the same day as the abortion, or the day prior to the abortion. *Id.*

There is no typical abortion patient, and pregnant people seek abortions for a variety of deeply personal reasons. *Id.* ¶¶ 49, 58; see also *id.* ¶¶ 52–57. In addition to cisgender women, gender-nonconforming people, transmasculine people, and trans men have abortions. *Id.* ¶ 49.

Nearly 60% of abortion patients nationally already have at least one child. *Id.* ¶ 50. Some people have abortions because they conclude that it is not the right time in their lives to have a child or to add to their families. *Id.* ¶¶ 49–50. Some decide to have an abortion because they do not want children at all. *Id.* ¶ 49.

Some people seek abortions because they are experiencing intimate partner violence and fear that carrying the pregnancy to term and giving birth would further tie them to their abusers. *Id.* ¶ 53. Some people seek abortions because the pregnancy is the result of rape. *Id.* ¶ 54.

Some people decide to have an abortion because of an indication or diagnosis of a fetal medical condition, including diagnoses that mean after delivery the baby would never be healthy enough to go home. *Id.* ¶ 56. While some may decide to carry such a pregnancy through delivery, others may decide that they wish to terminate the pregnancy. *Id.*

Some abortion patients experience pregnancy complications that lead them to end their pregnancies to preserve their own life or health. *Id.* ¶ 57.

The decision to terminate a pregnancy is often motivated by a combination of complex and interrelated factors that are intimately tied to the pregnant person's identity and values, mental and

physical health, family circumstances, and resources and economic stability. *Id*. ¶ 58.

STANDARD OF REVIEW

Under MCR 2.116(C)(10), if "[e]xcept as to the amount of damages, there is no genuine issue as to any material fact, . . . the moving party is entitled to judgment or partial judgment as a matter of law." In considering a motion brought under MCR 2.116(C)(10), a court considers affidavits, pleadings, depositions, admissions, and other evidence submitted by the parties. Summary disposition may be granted if the affidavits or other documentary evidence show there is no genuine issue with respect to any material facts. *Smith v Globe Life Ins Co*, 460 Mich 446, 454–455; 597 NW2d 28 (1999). The moving party has the initial burden of supporting its position with documentary evidence. If met, the burden shifts to the opposing party to establish that a genuine issue of disputed fact exists. *Barnard Mfg Co, Inc v Gates Performance Engg, Inc*, 285 Mich App 362, 363–364, 371–376; 775 NW2d 618 (2009). The non-moving party cannot simply rely on allegations or denials in the pleadings, but must go beyond the pleadings to set forth specific facts showing the existence of a genuine issue of material fact. *Smith*, 460 Mich at 455.

Additionally, permanent injunctive relief is warranted when "justice requires it," "there is no adequate remedy at law," and "there exists a real and imminent danger of irreparable injury." *Higgins Lake Property Owners Ass'n v Gerrish Twp*, 255 Mich App 83, 106; 662 NW2d 387 (2003), quoting *Head v Phillips Camper Sales & Rental, Inc*, 234 Mich App 94, 110; 593 NW2d 595 (1999). The court further considers: "(a) the nature of the interest to be protected, (b) the relative adequacy to the plaintiff of injunction and of other remedies, (c) any unreasonable delay by the plaintiff in bringing suit, (d) any related misconduct on the part of the plaintiff, (e) the relative hardship likely to result to defendant if an injunction is granted and to plaintiff if it is denied, (f) the interests of third persons and of the public, and (g) the practicability of framing and

enforcing the order or judgment." *Kernan v Homestead Dev Co*, 232 Mich App 503, 514; 591 NW2d 369 (1998).

ARGUMENT

As a matter of law, banning abortion violates the Michigan Constitution's rights to bodily integrity, equal protection, liberty, and privacy, as well as ELCRA. Accordingly, the only material factual issue in this case is whether the Criminal Abortion Ban will prevent people from accessing abortion in Michigan if the statute is not enjoined. There can be no real dispute that it would. Further, Plaintiffs' claim that the Criminal Abortion Ban is unconstitutionally vague is likewise based on the language and judicial constructions of the statute; no factual disputes are material to this claim. The Court should therefore grant summary disposition under MCR 2.116(C)(10) and enter a declaratory judgment and permanent injunction.

I. THE CRIMINAL ABORTION BAN IS UNCONSTITUTIONAL AS A MATTER OF LAW

Multiple provisions of the Michigan Constitution prohibit the state from banning abortion. No factual inquiry is needed to support this conclusion as a matter of law, so it is appropriately resolved by summary disposition under MCR 2.116(C)(10).

As a threshold matter, since Michigan's Constitution stands independent of the federal constitution, Michigan courts are not bound by the contours of federal constitutional doctrine in applying any given state constitutional guarantee. See *Glover v Mich Parole Bd*, 460 Mich 511, 522; 596 NW2d 598 (1999); *Bauserman v Unemployment Ins Agency*, 503 Mich 169, 185 n 12; 931 NW2d 539 (2019); *Gilmore v Parole Bd*, 247 Mich App 205, 222; 635 NW2d 345 (2001); *Sitz v Dep't of State Police*, 443 Mich 744, 761–762; 506 NW2d 209 (1993). Michigan courts are "free to find that an individual has greater rights under a Michigan constitutional provision than

under its federal counterpart when compelling reasons to do so exist," *Glover*, 460 Mich at 522, "even where the language is identical," *People v Goldston*, 470 Mich 523, 534; 682 NW2d 479 (2004). Further, "'compelling reason' should not be understood as establishing a conclusive presumption artificially linking state constitutional interpretation to federal law." *Sitz*, 443 Mich at 758. As the Court explained in *Sitz*:

> [T]he courts of this state should reject unprincipled creation of state constitutional rights that exceed their federal counterparts. On the other hand, our courts are not obligated to accept what we deem to be ***a major contraction of citizen protections*** under our constitution simply because the United States Supreme Court has chosen to do so. We are obligated to interpret our own organic instrument of government. [*Id.* at 763 (emphasis added).]

This Court is now faced with just such a scenario. The United States Supreme Court has just now, and for the first time in modern history, completely eviscerated a constitutional right previously recognized as fundamental under our federal constitution— a "major contraction of citizen protections" under the Due Process Clause of the Fourteenth Amendment, *Sitz*, 443 Mich at 763. The courts of this state are thus now "obligated to interpret" Michigan's constitution as an independent source of its citizens' rights. *Id.* As described below, the Criminal Abortion Ban violates multiple rights independently guaranteed by the Michigan Constitution, and should be declared unconstitutional.

A. The Criminal Abortion Ban Violates the Michigan Constitution's Right to Bodily Integrity

As the Court explained in its preliminary-injunction opinion, the Michigan Constitution's due process right to bodily integrity includes a person's "right to make decisions about the health events most likely to change the course of her life: pregnancy and childbirth." Op, p 23. The Criminal Abortion Ban strips people of their bodily integrity by forcing them to remain pregnant against their will. It is therefore unconstitutional as a matter of law.

1. The Michigan Right to Bodily Integrity Stands Independent of the Federal Right.

Michigan courts have recognized that substantive rights under the Michigan Constitution's Due Process Clause, Const 1963, art 1, § 17, share roots with—but stand independent of—the substantive due process rights protected under the federal constitution. See *AFT Mich v Michigan*, 497 Mich 197, 245; 866 NW2d 782 (2015) (recognizing that the Michigan Due Process Clause "may, in particular circumstances, afford protections greater than or distinct from those offered by [the federal Due Process Clause]"); *Delta Charter Twp v Dinolfo*, 419 Mich 253, 276 n 7; 351 NW2d 831 (1984) (basing its decision "solely" on the Michigan Due Process Clause even though "standards under the Michigan Constitution have been largely influenced by decisions of the United States Supreme Court"); *Mays v Governor*, 506 Mich 157, 217; 954 NW2d 139 (2020) (MCCORMACK, C.J., concurring) ("[W]e are separate sovereigns. We decide the meaning of the Michigan Constitution and do not take our cue from any other court, including the highest Court in the land.").

The essence of the substantive due-process right to bodily integrity is a protection against nonconsensual bodily intrusions. *Id.* at 192–195 (opinion of the Court). In *Mays*, a case arising from the Flint water crisis, the Court of Appeals held that the plaintiffs had adequately pled a violation of the right to bodily integrity under the Michigan Constitution where they alleged that the state defendants' decision to switch Flint's water source to the Flint River caused "an egregious, nonconsensual entry into the body . . . . " *Mays v Snyder*, 323 Mich App 1, 60; 916 NW2d 227 (2018), quoting *Rogers v City of Little Rock, Ark*, 152 F3d 790, 797 (CA 8, 1998). The Supreme Court affirmed by equal division the Court of Appeals' decision recognizing a claim under the state constitution's due process right to bodily integrity. *Mays*, 506 Mich at 192–195.

Concurring in the Supreme Court's decision in *Mays*, Justice Bernstein explained that the Michigan right to bodily integrity has independent origins specific to this state: "common notions of liberty *in this state* are so inextricably intertwined with physical freedom and freedom from state incursions into the body that Michigan's Due Process Clause plainly encompasses a right to bodily integrity." 506 Mich at 212–213 (BERNSTEIN, J., concurring) (emphasis added). As the Court of Appeals recognized in *In re Rosebush*, 195 Mich App 675, 680; 491 NW2d 633 (1992), "Michigan recognizes and adheres to the common-law right to be free from nonconsensual physical invasions and the corollary doctrine of informed consent." See also *In re Martin*, 200 Mich App 703, 710–711; 504 NW2d 917 (1993). This common-law doctrine predates the adoption of Michigan's 1963 Constitution. E.g., *Schloendorff v Society of NY Hosp*, 211 NY 125, 129–130; 105 NE 92 (1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body."), abrogated on other grounds by *Bing v Thunig*, 2 NY2d 656 (1957). And as this Court recognized in its preliminary-injunction opinion, federal bodily-integrity cases in fact draw support from "notions of liberty" advanced most prominently by Michigan Supreme Court Justice Thomas M. Cooley in 1879. Op, pp 17–18.

As with other constitutional rights, Michigan courts have not hesitated to stake out constitutional ground under the Due Process Clause of the Michigan Constitution separate and distinct from the due process rights protected by the United States Constitution, even though the legal standards governing the two provisions may overlap. In *Delta Charter Twp v Dinolfo*, 419 Mich at 267–278 & n 7, for example, the Michigan Supreme Court held that an ordinance limiting the number of unrelated individuals who may occupy a single-family dwelling violated the Due Process Clause of the Michigan Constitution even though United States Supreme Court precedent compelled the Court to conclude that the ordinance did not violate the Due Process Clause of the

Fourteenth Amendment. Similarly, in *People v Victor*, 287 Mich 506; 283 NW 666 (1939), the Michigan Supreme Court "found a statute prohibiting the giving away of drinking glasses at gas stations to be . . . in violation of the Due Process Clause of the Michigan Constitution, despite that . . . the United States Supreme Court had upheld a similar law" against a federal due-process challenge. *Dinolfo*, 419 Mich at 276 n 7. As the Court explained in *Dinolfo*, even though the due-process standard under the Michigan Constitution "has its roots in federal constitutional law," "[w]e did not there and we do not now hesitate to reach a conclusion different from that reached by the United States Supreme Court when it is warranted." *Id*.

Accordingly, Michigan courts are not constrained by federal court interpretations, including any part of *Dobbs*, in determining whether Michigan laws violate the Michigan right to bodily integrity.

2. The Michigan Right to Bodily Integrity Protects the Right to Abortion.

While the Michigan Supreme Court has yet to address the state due-process right to bodily integrity in the context of abortion, the bodily-integrity right to abortion is a traditionally protected interest such that it warrants recognition. See *Phillips v Mirac, Inc*, 470 Mich 415, 434; 685 NW2d 174 (2004) (a fundamental right affects "an interest traditionally protected by our society"); see also *People v Kevorkian*, 447 Mich 436, 477; 527 NW2d 714 (1994) (in a federal constitutional challenge, articulating that a right exists when it arises from "a rational evolution of tradition" such that its recognition does not constitute "a radical departure from historical precepts"). As explained above, the common-law doctrine of informed consent in medical decision-making has long been recognized in Michigan, and the right to determine whether to remain pregnant and to undergo labor and delivery is "a rational evolution" of this principle. *In re Rosebush*, 195 Mich App 675, 680. This Court has properly recognized that "the link between the right to bodily integrity and the

decision whether to bear a child is an obvious one," noting that "[f]orced pregnancy, and the concomitant compulsion to endure medical and psychological risks accompanying it, contravene the right to make autonomous medical decisions." Op, pp 21, 22.

Other states that have addressed this issue have also recognized a state constitutional right to bodily integrity that encompasses abortion and derives from the common-law doctrine of informed consent. In *Moe v Secretary of Administration & Finance*, 382 Mass 629, 648–649; 417 NE2d 387 (1981), the Supreme Judicial Court of Massachusetts recognized that the state constitutional "right to make the abortion decision privately" was "but one aspect of a far broader constitutional guarantee" related to, among other things, the "strong interest in being free from nonconsensual invasion of . . . bodily integrity . . . ." (Citation omitted.) Similarly, in *Hodes & Nauser, MDs, PA v Schmidt*, 309 Kan 610; 440 P3d 461 (2019) (per curiam), the Supreme Court of Kansas held that a state law banning the most common method of second-trimester abortion was likely to violate the state constitutional right to bodily integrity because it required people seeking abortions at that stage of pregnancy to undergo riskier and more invasive procedures instead, *id.* at 616–618, 646–650, 678. Moreover, the bodily-integrity right to abortion under the Michigan Constitution is "an interest traditionally protected by our society," *Phillips*, 470 Mich at 434, and is certainly not "a radical departure from historical precepts," *Kevorkian*, 447 Mich at 477. The Criminal Abortion Ban's legislative history reveals a historical allowance for abortion at least before viability, and after viability where necessary to preserve the patient's life or health. Under common law, it was not a crime to terminate a pregnancy prior to "quickening," which was a stand-in for viability. *People v Nixon*, 42 Mich App 332, 335; 201 NW2d 635 (1972), remanded

389 Mich 809 (1973), on remand 50 Mich App 38 (1973).[5] As historian James Mohr recounts, the Michigan State Board of Health received the following testimony in 1876, which Mohr characterizes as representative: "There is very generally current among the people the notion that before a pregnant woman 'quickens,' *i.e.* before the fourth month of pregnancy, there is no real life in the fetus, or at least that it is not a 'living soul,' and to destroy it is no real crime." Mohr, *Abortion in America: The Origins and Evolution of National Policy, 1800–1900* (New York: Oxford University Press, 1978), p 73.

Mid-nineteenth century versions of the Criminal Abortion Ban further demonstrate that the Legislature's criminalization of abortion as a felony began only after "quickening," see *Nixon*, 42 Mich App at 335–336 & nn 5–7, citing & quoting 1846 RS, ch 153, §§ 32–34, and reflect a recognition that before quickening a woman retained a right to make choices regarding her pregnancy, and statutes regulating abortions arose out of a desire to protect women from unsafe methods of terminating pregnancies, *id.* at 335–337 ("If the purpose of the statute was not to protect the fetus, what then was its intended purpose? The obvious purpose was to protect the pregnant woman.").

However, in 1972 the Court of Appeals recognized that, "medical science has probably advanced more in one generation than in the previous one hundred years or more. Legal philosophy and precedent have moved in response to scientific and popular knowledge." *Nixon*, 42 Mich App at 338–339, quoting *Womack v Buchhorn*, 384 Mich 718, 720; 187 NW2d 218 (1971). In light of the fact that modern abortion was now safer than childbirth, the Court of Appeals found that the

[5] Quickening was defined as the point in pregnancy when the pregnant person could first sense fetal movement, generally recognized as occurring in the fourth or fifth month of pregnancy. *Nixon*, 42 Mich App at 335 n 3, citing *Stedman's Medical Dictionary* (21st ed), p 1340. The Court of Appeals has construed "quick child" to mean "a viable child in the womb of its mother." *Larkin v Cahalan*, 389 Mich 533, 541; 208 NW2d 176 (1973).

Criminal Abortion Ban not only failed to advance an interest in "the health and safety of the woman," but "it has become counter-productive." *Id.* at 340.

The following year, the United States Supreme Court in *Roe* recognized the federal right to abortion and the Michigan Supreme Court in *Bricker* construed the Criminal Abortion Ban consistent with federal rulings to allow abortions before viability, and after viability where necessary to preserve the patient's life or health. Meanwhile, in *Larkin v Cahalan*, 389 Mich 533; 208 NW2d 176 (1973), the Michigan Supreme Court construed the Criminal Abortion Ban's companion statute MCL 750.323—criminalizing as manslaughter the provision of abortion to a "woman pregnant with a quick child"—to apply only after viability, reasoning that a "child" in this context referred to a fetus "so far developed and matured as to be capable of surviving the trauma of birth with the aid of the usual medical care and facilities available in the community," *Larkin*, 389 Mich at 541–542. For the nearly fifty years since *Nixon*, *Roe*, *Bricker*, and *Larkin*, people in Michigan have relied upon access to safe, legal abortion before viability, and after viability to preserve the patient's life or health. See also Wallett Aff ¶¶ 3–4, 11–13, 71.

This history demonstrates that a right to bodily integrity, protecting the right to abortion before viability and after viability to preserve the patient's life or health, is one that "arises from a rational evolution of tradition." *Kevorkian*, 447 Mich at 477. Recognizing this right in the context of abortion would not require "a radical departure from historical precepts." *Id.* Indeed, history compels it. As this Court concluded in its preliminary-injunction opinion, "after nearly fifty years of legal abortion in Michigan, there can be no doubt but that the right of personal autonomy and bodily integrity enjoyed by our citizens includes the right of a woman, in consultation with her physician, to terminate a pregnancy." Op, p 24.

3. The Criminal Abortion Ban Violates the Michigan Right to Bodily Integrity Because it is Not Narrowly Tailored to Promote a Compelling Government Interest.

Forcing someone to remain pregnant against their will is a fundamental violation of their right to "to the possession and control of [one's] own person." See *Mays*, 506 Mich at 212 (BERNSTEIN, J., concurring), quoting *Union Pac R Co v Botsford*, 141 US 250, 251; 11 S Ct 1000; 35 L Ed 734 (1891). Specifically, the Criminal Abortion Ban infringes the Michigan Constitution's protection against bodily integrity by preventing people from exercising autonomy over their bodies and their lives, and by forcing pregnant people to endure labor and delivery, face increased medical risk, and risk more invasive medical interventions without their consent. Because the Ban infringes this fundamental constitutional right, strict scrutiny applies. The Ban is not narrowly tailored to promote a compelling government interest, so it violates the right to bodily integrity.

For a host of reasons, the decision to become or remain pregnant is one of the most personal and consequential a person will make in their lifetime. See Wallett Aff ¶¶ 19–41. By preventing people in Michigan from ending their pregnancies, the Criminal Abortion Ban forces them to submit to nearly ten months of dramatic physical transformation, implicating the most personal aspects of their lives and identities, without their consent. See *id.* ¶¶ 19–4. The Criminal Abortion Ban therefore implicates the right to bodily integrity.

The Criminal Abortion Ban also implicates the right to bodily integrity by forcing pregnant people to endure increased physical risk, including an increased risk of death, and more invasive medical interventions such as delivery by C-section. Wallett Aff ¶¶ 21–34, 42. These very risks and interventions were recognized by the Kansas Supreme Court as likely to violate that state's constitutional right to bodily integrity. *Hodes & Nauser*, 309 Kan at 616–618, 646–650, 678.

Because the Criminal Abortion Ban infringes on the right to bodily integrity, it can be justified only if it is narrowly tailored to promote a compelling government interest. *Doe v Dep't*

of Social Servs, 439 Mich 650, 662; 487 NW2d 166 (1992); cf. *Guertin v Michigan*, 912 F3d 907, 919 (CA 6, 2019) ("[I]ndividuals possess a constitutional right to be free from forcible intrusions on their bodies against their will, absent a compelling state interest." (citation omitted)). The Ban plainly fails the demanding strict-scrutiny standard.

Assuming that the Criminal Abortion Ban's purported purpose—to protect against unsafe abortions, *Nixon*, 42 Mich App at 337–339—is a compelling one, it is far from narrowly tailored to advance that interest. The Criminal Abortion Ban has already been found not to advance the law's actual purpose of protecting the health and safety of pregnant people in Michigan. See *id.* at 337–339. To the contrary, the Ban exposes pregnant people to an increased risk of illness, serious bodily injury, and death, thus rendering it "counter-productive." *Id.* at 340; Wallett Aff ¶¶ 21–34, 42. Accordingly, regardless whether the state's interest is deemed "compelling," "important," or "legitimate," it cannot categorically justify this profound physical intrusion of forced pregnancy and childbirth.

B. The Criminal Abortion Ban Violates Equal Protection Guarantees Under the Michigan Constitution

The Criminal Abortion Ban also violates the Michigan Constitution's Equal Protection Clause, Const 1963, art 1, § 2. First, the Ban treats two similarly situated classes—pregnant people who seek to carry their pregnancies to term and pregnant people who seek to have abortions—differently without adequate justification, and, as to the latter class, infringes the fundamental right to bodily integrity under the Michigan Constitution. Second, the Ban is a sex-based classification that enforces antiquated and overbroad generalizations about women and requires women to undertake greater risks than men to their health and financial stability, and constrains their ability to exercise personal autonomy over their future.

"When reviewing the validity of state legislation or other official action that is challenged as denying equal protection, the threshold inquiry is whether [a] plaintiff was treated differently from a similarly situated entity." *Shepherd Montessori Ctr Milan v Ann Arbor Charter Twp*, 486 Mich 311, 318; 783 NW2d 695 (2010). Then, if the difference in treatment infringes on a fundamental right or is based on a suspect classification, it is subject to heightened scrutiny. *Id.* at 319. Although Michigan courts deciding equal protection cases have employed a mode of analysis "similar" to that of the United States Supreme Court, *Doe*, 439 Mich at 662, "a state court is entirely free to read its own State's constitution more broadly than [the United States Supreme Court] reads the Federal Constitution, or to . . . favor . . . a different [mode of] analysis of its corresponding constitutional guarantee," *City of Mesquite v Aladdin's Castle, Inc*, 455 US 283, 293; 102 S Ct 1070; 71 L Ed 2d 152 (1982).

Here, the Criminal Abortion Ban both infringes on a fundamental right and is based on a suspect classification, and is unconstitutional on both grounds.

1. The Criminal Abortion Ban Violates the Michigan Right to Equal Protection Because it Denies Pregnant People their Fundamental Right to Bodily Integrity, Liberty, and Privacy.

First, the Ban infringes on the exercise of a pregnant person's right to decide whether to remain pregnant, which is a component of their fundamental rights to bodily integrity, liberty, and privacy. The Ban treats differently two classes of similarly situated people exercising those fundamental rights: pregnant people who seek to terminate their pregnancy, and those who seek to continue their pregnancy to childbirth. Under the Ban, pregnant people who choose childbirth can more fully and without comparable government restriction exercise their rights to liberty, privacy, and bodily integrity, by making highly personal decisions about their bodies, while those who seek

to terminate their pregnancies are in almost all instances unable to do so. See MCL 750.14. The two groups are similarly situated but treated differently.

Where, as here, legislation that treats similarly situated people differently infringes on a fundamental right, the court must employ strict scrutiny. *Doe*, 439 Mich at 662. When strict scrutiny is the test, it is the state's burden to establish that "the classification drawn is narrowly tailored to serve a compelling governmental interest." *Shepherd Montessori Ctr*, 486 Mich at 319. Assuming that the Criminal Abortion Ban's purported purpose—to protect against unsafe abortions, *Nixon*, 42 Mich App at 337–339—is a compelling one, it is far from narrowly tailored to advance that interest. Abortions provided by licensed clinicians are highly safe, and are in fact safer than giving birth. See Wallett Aff ¶ 42. Not only does the Ban fail to advance an interest in "the health and safety of the woman," but "it has become counter-productive." *Nixon*, 42 Mich App at 340. By forcing people who do not wish to be pregnant to remain so and endure labor and delivery, the Ban exposes them to more medical risk than abortion. See Wallett Aff ¶¶ 21–34.

In sum, justifications rooted in protecting the health and safety of those who become pregnant fail to stand up to constitutional scrutiny given how safe and common abortion is. See *supra* pp 9-10, 20-21. Thus, the Criminal Abortion Ban fails strict scrutiny because it is not necessary to further a compelling state interest and is not "precisely tailored" to that end. *Doe*, 439 Mich at 662.

2. The Criminal Abortion Ban is a Sex-Based Classification that Denies Women Equal Protection of the Laws.

Second, the Criminal Abortion Ban relies on a suspect classification because it is sex-based. On its face the Ban applies only to women, and in operation it enforces the archaic, sex-based stereotype that the biological capacity for pregnancy should determine the course of a person's life. Such sex-based classification schemes are subject to heightened scrutiny. *Dep't of*

Civil Rights ex rel Forton v Waterford Twp Dep't of Parks & Rec, 425 Mich 173; 387 NW2d 821 (1986).

The Criminal Abortion Ban creates sex-based classifications in its text by specifically and repeatedly singling out the "pregnant *woman*" and "such *woman*." MCL 750.14 (emphasis added). By its terms, the Ban deprives women, and not men, of the ability to make choices about whether or not to have children. Pregnancy-based classifications are sex-based classifications under Michigan law because they are justified by reference to physical differences between men and women. *Mich Dep't of Civil Rights ex rel Jones v Mich Dep't of Civil Serv*, 101 Mich App 295, 304; 301 NW2d 12 (1980). In relying on these physical differences to justify differential treatment, such classifications codify sex-based stereotypes "that reflect[] 'old notions and archaic and overbroad' generalizations about the roles and relative abilities of men and women." *Heckler v Mathews*, 465 US 728, 745; 104 S Ct 1387; 79 L Ed 2d 646 (1984), quoting *Califano v Goldfarb*, 430 US 199, 211; 97 S Ct 1021; 51 L Ed 2d 270 (1977) (plurality opinion). Under Michigan law, these distinctions "work[] to deny women valuable rights solely on account of their sex." *Jones*, 101 Mich App at 304. Distinctions drawn on the basis of pregnancy, therefore, are suspect classifications under the Michigan Constitution.

The Criminal Abortion Ban also evidences discriminatory intent by enforcing sex-based stereotypes that, even if commonplace decades ago, are now obsolete and recognized as harmful and degrading. Principal among these stereotypes was the idea that "the female [was] destined solely for the home and the rearing of the family, and only the male for the marketplace and the world of ideas." *Stanton v Stanton*, 421 US 7, 14–15; 95 S Ct 1373; 43 L Ed 2d 688 (1975); see also *City of Cleburne, Tex v Cleburne Living Ctr*, 473 US 432, 441; 105 S Ct 3249; 87 L Ed 2d 313 (1985). The Ban originated during the nineteenth century, see 1846 RS, ch 153, §§ 32–34,

amid a national campaign against women who sought control of their reproductive life, see *Abortion in America*, *supra*, pp 128–129. "The antiabortion campaign repeatedly insisted that women's reproductive conduct demanded regulation . . . ." Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 Stan L Rev 261, 300 (1992). Leading advocates of criminalizing abortion defined abortion as "a female crime" and a breach of marital duty, and accused women who sought abortion of being "lazy," going against the maternal instinct, and "avoid[ing] the labor of caring for and rearing children." *Id*. at 300–303, quoting Gardner, *Physical Decline of American Women*, reprinted in Gardner, *Conjugal Sins Against the Law of Life and Health* (New York: J.S. Redfield, 1870), pp 199, 230 ("Is it not arrant laziness, sheer, craven, culpable cowardice, which is at the bottom of this base act? . . . . Have you the right to choose an indolent, selfish life, neglecting the work God has appointed you to perform?"). It was amid this national sentiment that New York passed one of the first laws criminalizing abortion. The New York law was motivated by both "[d]istress over falling birthrates" and the view that "[w]omen had to be saved from themselves." *Abortion in America*, pp 128, 129. A year later, Michigan passed MCL 750.14's predecessor statutes, which closely tracked the language of the New York statute. 1846 RS, ch 153, § 34; *Abortion in America*, pp 129–130.

Such antiquated notions "may not be used, as they once were, to create or perpetuate the legal, social, and economic inferiority of women." *United States v Virginia*, 518 US 515, 533–534; 116 S Ct 2264; 135 L Ed 2d 735 (1996). *United States v Virginia* cited with disapproval *Goesaert v Cleary*, 335 US 464, 467; 69 S Ct 198; 93 L Ed 163 (1948), in which a 1945 Michigan statute prohibiting most women from obtaining bartender licenses was upheld, *id.* at 465, 467. By forcing women to carry pregnancies to term because of their sex, the Criminal Abortion Ban attempts to

conscript them to "the home and the rearing of the family," *Stanton*, 421 US at 14, despite the greater risks to their physical and mental health,[6] financial stability,[7] and ability to seek out life opportunities[8] that result, see *supra* pp 9-10, and which are more than what is expected of and endured by men. In this way, the Criminal Abortion Ban perpetuates the subordination of women.

Where legislation creates a classification based on sex or gender, it is reviewed under the "intermediate" or "heightened scrutiny" test and fails constitutional muster unless it is substantially related to an important government interest. *People v Idziak*, 484 Mich 549, 570–571; 773 NW2d 616 (2009). Heightened scrutiny requires an "exceedingly persuasive" justification, *Communities for Equity v Mich High Sch Athletic Ass'n*, 459 F3d 676, 692–693 (CA 6, 2006), quoting *Virginia*, 518 US at 531, and "must not rely on overbroad generalizations about the different talents, capacities, or preferences of males and females," *Virginia*, 518 US at 533.

As discussed previously, the State cannot meet that bar. The State's proffered justification of protecting women from unsafe abortions, see *Nixon*, 42 Mich App at 337–339, not only lacks a

[6] Wallet Aff ¶¶ 22–34, 38–39; Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215 (2012) (concluding that the risk of death associated with childbirth is approximately 14 times higher than with abortion).

[7] Wallett Aff ¶¶ 35–37, 40–41; Advancing New Standards in Reproductive Health, *Factsheet: The Harms of Denying a Woman a Wanted Abortion* (April 22, 2020), available at <https://www.ansirh.org/research/sheet/harms-denying-woman-wanted-abortion> (reporting on study finding that women who were turned away from abortion and went on to give birth "experienced an increase in household poverty lasting at least four years relative to those who received an abortion," "were more likely to not have enough money to cover basic living expenses like food, housing and transportation," and "lowered a woman's credit score, increased a woman's amount of debt and increased the number of their negative public financial records, such as bankruptcies and evictions"); Biggs et al, *Understanding Why Women Seek Abortions in the US*, 13 BMC Women's Health 29 (2013) (finding the reasons women seek abortion are complex and interrelated, with the predominant themes including financial reasons (40%), timing (36%), partner related reasons (31%), and the need to focus on other children (29%)).

[8] Wallet Aff ¶¶ 22–41, 80–81.

basis in fact, see *supra* pp 9-10, 25, but it is also paternalistic—it relies on "overbroad generalizations" about the capacity of women to make their own medical decisions in consultation with trusted health care providers. These paternalistic justifications were commonplace at the time the Ban's predecessor statutes were passed. A leading physician in the campaign to ban abortion, Dr. Horatio Storer, argued that because childbearing is the "end for which [women] are psychologically constituted and for which they are destined by nature," termination of pregnancy was "disastrous to a woman's mental, moral, and physical well-being." See Storer, *Why Not? A Book for Every Woman*, 75–76 (Boston: Lee & Shepard, 1866). Physicians claimed that abortion would "insidiously undermine[]" women's reproductive organs, and "permanently incapacitate[] [women] for conception," *id*. at 50, and that a woman who has an abortion "destroys her health … [and] sooner or later comes upon the hands of the physician suffering with uterine disease," Phelps, *Criminal Abortion: Read Before the Calhoun County Medical Society*, 1 Detroit Lancet 725, 728 (1878). Justifications for anti-abortion legislation based on protecting women's health are overtly and invariably based on sex stereotypes. See Brief of Equal Protection Constitutional Law Scholars Serena Mayeri, Melissa Murray, and Reva Siegel as Amici Curiae in Support of Respondents, pp 14–16, *Dobbs v Jackson Women's Health Org*, (US, September 20, 2021) (Docket No. 19-1392). For that reason, and because the Criminal Abortion Ban directly undermines rather than supports the State's purported interest in protecting women's health, see *supra* pp 9-10, 25, it cannot be substantially related to furthering that interest and cannot survive heightened scrutiny under the Equal Protection Clause of the Michigan Constitution.

C. The Criminal Abortion Ban Violates ELCRA

Michigan's Criminal Abortion Ban violates ELCRA because it deprives women of "the full and equal enjoyment" of public services and accommodations, as well as their ability to

exercise their constitutional rights. MCL 37.2302(a). The Supreme Court has recognized that ELCRA: (1) "enlarge[s] the scope of civil rights" to include protection from discrimination on the basis of sex in public accommodations, housing, education, and employment, *Dep't of Civil Rights ex rel Forton*, 425 Mich at 186; and (2) also protects against "state action violations that amount to constitutional deprivation" in public services, *id.* Both of these components are violated here.

First, the Criminal Abortion Ban, by forcing women to remain pregnant without their consent, will cause them to be deprived of their civil rights in public accommodations, housing, education, and employment because of their sex. As discussed above, the Criminal Abortion Ban enforces a sex stereotype that women are meant to produce and raise children rather than take full advantage of opportunities in education and employment. See *supra* pp 25-29. Enforcing the statute as written would make abortion virtually unavailable and thereby reduce women's access to education.[9] Similarly, forcing women to carry pregnancies to term limits their access to equal employment opportunities because pregnancy and childrearing significantly impact a woman's wage potential and career trajectory.[10] These denials of equal access violate ELCRA. *Cf Clarke v K Mart Corp*, 197 Mich App 541, 545; 495 NW2d 820 (1992).

[9] See Jones, *At a Crossroads: The Impact of Abortion Access on Future Economic Outcomes*, Am Univ Working Paper, pp 14–15 (2021) (finding that "access to abortion from age 15 to 23 increases years of education by 0.80 (6%), increases the probability of entering college by 0.21 (41%) and increases the probability of completing college by 0.18 (72%)"); see also Wallett Aff ¶¶ 49, 52.

[10] See Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 Am J Pub Health 407, 409 (2018) (finding unemployment rates significantly higher among group forced to carry a pregnancy to term at six months after abortion was sought); see also Wallett Aff ¶¶ 49, 80–81; Jones, *supra* note 9, at 16 ("[A]bortion access increases a woman's earnings later in life by $11,000 to $15,000/year as measured in 2018 USD, about a 37% increase, and increases family income by $6,000 to $10,000/year, a 10% increase."); Malik et al, *America's Childcare Deserts in 2018*, Ctr for Am Progress (December 6, 2018) <https://www.americanprogress.org/issues/early-childhood/reports/

Second, because state action enforcing the law is a public service under ELCRA, see *Forton*, 425 Mich at 188, enforcement of the Criminal Abortion Ban will also violate ELCRA by discriminating against women because of their sex. The Attorney General's office performs a public service as a public agency of the State of Michigan. See MCL 37.2301(b). Indeed, services engaged in by government actors, including law enforcement, have long been identified as a public service under ELCRA. See, e.g., *Reed v Detroit*, __ F Supp __; 2021 WL 3087987, slip op at *2 (ED Mich, July 22, 2021) (Docket No. 2:20-CV-11960) (law enforcement); *Does 11–18 v Dep't of Corrections*, 323 Mich App 479, 485; 917 NW2d 730 (2018) (prisons). By enforcing the Criminal Abortion Ban, the state would be performing a public service that discriminates against women by depriving women of the full and equal privileges of their constitutional rights under the Michigan Constitution.

Accordingly, in addition to the Criminal Abortion Ban violating the Michigan Constitution directly, enforcing the Ban would violate ELCRA.

D. The Criminal Abortion Ban Violates the Retained Rights Clause of the Michigan Constitution

The Michigan Constitution's Retained Rights Clause, Const 1963, art 1, § 23, which provides that "[t]he enumeration in this constitution of certain rights shall not be construed to deny or disparage others retained by the people," also establishes a fundamental right to abortion.

The Retained Rights Clause was added during the 1961-62 Constitutional Convention. 1 Official Record, Constitutional Convention, 1961-62, pp 466, 470. Its purpose was explicit: "The language recognizes that no bill of rights can ever enumerate or guarantee all the rights of the people and that *liberty under law is an ever growing and ever changing conception of a living*

2018/12/06/461643/americas-child-care-deserts-2018/> (accessed June 21, 2022); Wallett Aff ¶¶ 40, 80–81.

society developing in a system of ordered liberty." *Id*., p 470 (emphasis added); see also 2 Official Record, Constitutional Convention 1961-62, p 3365 (stating that the section "recognizes that no Declaration of Rights can enumerate or guarantee all the rights of the people—*that it is presently difficult to specify all such rights which may encompass the future in a changing society*" (emphasis added)).

Thus it is clear that the voters who approved the 1963 Constitution understood that the individual state constitutional rights expressly named in the Declaration of Rights are not exhaustive of the rights recognized in 1963. Those voters also understood that the Retained Rights Clause clearly anticipated and authorized courts to recognize, infer, and enforce constitutional rights not textually recognized or specifically contemplated in 1963 based on changes in society. Michigan courts have done so. See, e.g., *Mays*, 506 Mich at 193 (recognizing a constitutional right to bodily integrity and describing the test for a bodily-integrity claim as asking whether governmental intrusion is "so egregious and outrageous that they shock the *contemporary* conscience" (emphasis added)).

This Court should recognize a state constitutional right to abortion under the Retained Rights Clause because societal conditions have changed and the very purpose of the Retained Rights Clause was to provide new rights recognizing changed conditions. Indeed, the authors of the Retained Rights Clause were prescient because the 1963 Constitution was adopted on the eve of epochal, revolutionary changes in civil rights. For example, on the statutory front from the 1964 Civil Rights Act, to the 1972 enactment of Title IX, to the 1976 adoption of ELCRA in Michigan, to a series of precedent-setting cases from the United States Supreme Court,[11] to enormous societal

[11] See, e.g., *Reed v Reed*, 404 US 71; 92 S Ct 251; 30 L Ed 2d 225 (1972) (a law which discriminates against women violates the 14th Amendment); *Frontiero v Richardson*, 411 US 677; 93 S Ct 1764; 36 L Ed 2d 583 (1973) (laws which differentiate by sex are inherently suspect and

changes of which the Court can take judicial notice, the subordinate legal status of women changed dramatically after 1963. These changes have fundamentally altered women's roles in Michigan society and Michigan women have built and lived their lives in reliance on this new world.

The Retained Rights Clause was added to the state constitution in anticipation that new rights, or new recognitions of what liberty entails, must often accompany such seismic changes in a growing society. As the United States Supreme Court recognized in a different context:

> The nature of injustice is that we may not always see it in our own times. The generations that wrote and ratified the [Constitution] did not presume to know the extent of freedom in all of its dimensions, and so they entrusted to future generations a charter protecting the right of all persons to enjoy liberty as we learn its meaning. When new insight reveals discord between the Constitution's central protections and a received legal stricture, a claim to liberty must be addressed. [*Obergefell v Hodges*, 576 US 644, 664; 135 S Ct 2584; 192 L Ed 2d 609 (2015).]

Such is the case here, and among those constitutional rights that must be recognized today is the right to abortion.

The best source to define the scope of the retained right to abortion is the Michigan common law. As this Court recognized in its preliminary-injunction opinion, "at common law, abortion performed before quickening was not an indictable offense." Op, p 1. Not only was a pre-quickening abortion *not* a crime at common law, but women had a common law *right* to terminate a pregnancy. As one scholar described it:

> English and American women enjoyed a *common-law liberty* to terminate at will an unwanted pregnancy, from the reign of Edward II to that of George III. The common-law liberty endured, in England, from 1327 to 1803; in American, from 1607 to 1830 [when states began to criminalize abortion]. [Means, *The Phoenix of Abortional Freedom: Is A Penumbral or Ninth Amendment Right About To Arise From The Nineteenth-Century Legislative Ashes of*

subject to heightened scrutiny); *Cleveland Bd of Educ v LaFleur*, 414 US 632; 94 S Ct 791; 39 L Ed 2d 52 (1974) (presumptions about pregnancy are unconstitutional).

> *A Fourteenth Century Common-Law Liberty?*, 17 NY Law Forum 337 (1971) (emphasis added).[12]

Recent scholarship thoroughly analyzing the common law confirms that there is a broad common-law right to terminate a pregnancy:

> Individuals hold—and as long as the common law has been in place, they have always held—a legal right to terminate their pregnancies. Their desire not to be pregnant is the only reason they need to exercise this common law right. The entitlement to end one's pregnancy before the birth of a child existed in the law of crimes, tort, property, contracts, and equity, read separately and together, long before the United States Supreme Court found it in the Constitution. [Bernstein, *Common Law Fundamentals of the Right to Abortion*, 63 Buffalo L Rev 1141, 1208 (2015) (footnotes omitted).]

See also Bernstein, *The Common Law Inside the Female Body* (Cambridge Univ Press, 2018) (a book-length development of the law review article's analysis). The well-developed common-law right of a woman to terminate her pregnancy establishes that there is a fundamental state constitutional right to abortion under the Retained Rights Clause that this Court should explicitly recognize.

[12] The Supreme Court in *Roe* also characterized the common law as creating a *right* of a woman to terminate a pregnancy:

> It is thus apparent that the common law, at the time of the adoption of our Constitution, and throughout the major portion of the 19th century, abortion was viewed with less disfavor than under most American statutes currently in effect. Phrasing it another way, *a woman enjoyed a substantially broader right to terminate a pregnancy* than she does in most States today. At least with respect to the early stage of pregnancy, and very possibly without such limitation, the opportunity to make this choice was present in this country well into the 19th century. [410 US at 140–141 (emphasis added).]

Likewise, the use of viability as a defining line for the right to abortion has its roots in the common law. The Michigan Supreme Court has equated the common-law concept of quickening with viability, stating that a quick child is

> a *viable* child in the womb of its mother; that is, an unborn child whose heart is beating, who is experiencing electronically measurable brain waves, who is discernably moving, and who is so far developed and matured as to be capable of surviving the trauma of birth with the aid of the usual medical care and facilities available in the community. [*Larkin*, 389 Mich at 541–542 (emphasis added).]

See also *Nixon*, 42 Mich App at 336–337 ("the unquickened fetus was not considered to be a separate human being").

For all these reasons, the Retained Rights Clause and the common law provide a basis for this Court to recognize a state constitutional right to pre-viability abortion and to post-viability abortion to protect the pregnant person's life or health.

E. The Michigan Constitution's Due-Process Right to Privacy Protects the Right to Abortion

Additionally, while lower courts are bound by the Court of Appeals' holding in *Mahaffey* that "the right of privacy under the Michigan Constitution does not include the right to abortion," 456 Mich App at 345, *Mahaffey* insufficiently considered the Michigan Constitution's support for an independent state-law right to abortion grounded in the privacy interests protected by its Due Process Clause, Const 1963, art 1, § 17. Accordingly, Plaintiffs preserve for appeal their claim that the Criminal Abortion Ban violates the right to privacy under the Due Process Clause of the Michigan Constitution.

As a threshold matter, the Michigan Constitution protects a right to privacy. *Advisory Opinion on Constitutionality of 1975 PA 227 (Questions 2–10)*, 396 Mich 465, 504–505; 242 NW2d 3 (1976). The Michigan Supreme Court, however, has never explicitly addressed whether the state constitutional right to privacy includes a right to abortion. See *Doe*, 439 Mich at 669–670

(summarizing arguments on "both sides concerning the existence of a separate state right to an abortion" but finding it "unnecessary to decide [the] issue" given that the federal right to abortion resolved the case). The Court of Appeals has twice considered whether an independent right to abortion exists under the Michigan Constitution and has come out both ways. Compare *Doe v Dir of Dep't of Social Servs*, 187 Mich App 493, 508; 468 NW2d 862 (1991) (finding a right to abortion under the Michigan Constitution), rev'd on other grounds 439 Mich 650 (1992), with *Mahaffey*, 222 Mich App at 345 (concluding that "the right of privacy under the Michigan Constitution does not include the right to abortion"), lv den 456 Mich 948 (1998). Therefore, this is an unsettled area of Michigan law. Despite the Supreme Court's silence, abortion falls squarely within the zone of privacy that is protected under Michigan's constitution, and the question whether the right to abortion is part of the state due-process right to privacy is ripe for Michigan Supreme Court review.

Other state courts have recognized a right to abortion stemming from their state constitutional rights to liberty and privacy. See, e.g., *Armstrong v State*, 296 Mont 361, 379; 989 P2d 364 (1999) ("Montana's constitutional right of individual privacy" guarantees "a woman's right to seek and obtain pre-viability abortion"); *Am Academy of Pediatrics v Lundgren*, 16 Cal 4th 307, 327; 940 P2d 797 (1997) (holding that "the right of a pregnant woman to choose whether to . . . have an abortion," is a "right of privacy" under the state constitution); *Hope v Perales*, 83 NY2d 563, 575; 634 NE2d 183 (1994) ("[T]he fundamental right of reproductive choice[] [is] inherent in the due process liberty right guaranteed by our State Constitution . . . ."); *Doe v Maher*, 40 Conn Supp 394, 426; 515 A2d 134 (1986) ("Surely, the state constitutional right to privacy includes a woman's guaranty of freedom of procreative choice."); *Right to Choose v Byrne*, 91 NJ

287, 303–304; 450 A2d 925 (1982) (acknowledging a state-law right to privacy includes whether to have an abortion).[13] The Michigan Supreme Court should reach the same conclusion here.

Finally, assuming the Michigan Constitution's right to privacy protects a fundamental right to abortion, the Criminal Abortion Ban's intrusion on that right is unconstitutional unless it is narrowly tailored to advance a compelling state interest. *Doe*, 439 Mich at 662; *Phillips v Mirac, Inc*, 470 Mich 415, 432–433; 685 NW2d 174 (2004). The Court of Appeals has already observed that the Criminal Abortion Ban's purpose—to protect pregnant people from unsafe abortions—is insufficient to justify the Criminal Abortion Ban given that abortion is safe as provided by licensed clinicians in Michigan. *Nixon*, 42 Mich App at 339; see also *supra* pp 9-11. Accordingly, the Ban does not survive strict scrutiny.

F. The Criminal Abortion Ban Is Unconstitutionally Vague

Finally, given the removal of the federal doctrine incorporated by *Bricker*, and the statute's own facial ambiguity, the Criminal Abortion Ban is unconstitutionally vague, which provides an independent basis for declaring it unconstitutional.

A statute is unlawfully vague if it "fails to provide fair notice of the proscribed conduct," or if it "is so indefinite that it confers unfettered discretion on the trier of fact to determine whether the law has been violated." *People v Rogers*, 249 Mich App 77, 94–95; 641 NW2d 595 (2001), citing *Woll v Attorney General*, 409 Mich 500, 533; 297 NW2d 578 (1980); *Plymouth Charter Twp v Hancock*, 236 Mich App 197, 200–201; 600 NW2d 380 (1999). "Vague laws may trap the innocent by not providing fair warning," and they "impermissibly delegate[] basic policy matters

[13] See also *Valley Hosp Ass'n v Mat-Su Coalition for Choice*, 948 P2d 963, 964, 968–969 (Alas, 1997) (striking down abortion restriction for violating Alaska's "fundamental right to [] abortion . . . encompassed within" the state's express right-to-privacy constitutional protection); *In re TW*, 551 So 2d 1186, 1192–1193 (Fla, 1989) (Florida's express privacy provision "is clearly implicated in a woman's decision of whether or not to continue her pregnancy.").

to policemen, judges, and juries for resolution on an ad hoc and subjective basis, with the attendant dangers of arbitrary and discriminatory application." *People v Lawhorn*, 320 Mich App 194, 198–99; 907 NW2d 832 (2017), quoting *Grayned v City of Rockford*, 408 US 104, 108–109; 92 S Ct 2294; 33 L Ed 2d 222 (1972).

"In determining whether a statute is unconstitutionally vague . . . , a reviewing court should consider the entire text of the statute and any judicial constructions of the statute." *Rogers*, 249 Mich App at 95. As stated, the text of the Criminal Abortion Ban makes it a felony to "wilfully administer to any pregnant woman any medicine, drug, substance or thing whatever, or . . . employ any instrument or other means whatever, with intent thereby to procure the miscarriage of any such woman, unless the same shall have been necessary to preserve the life of such woman." MCL 750.14. As for judicial construction, *Bricker* held as follows:

> In light of the declared public policy of this state and the changed circumstances resulting from the federal constitutional doctrine elucidated in *Roe* and *Doe* [*v Bolton*, 410 US 179; 93 S Ct 739, 35 L Ed 2d 201 (1973)], we construe [the Criminal Abortion Ban] to mean that the prohibition of this section shall not apply to 'miscarriages' authorized by a pregnant woman's attending physician in the exercise of his medical judgment; the effectuation of the decision to abort is also left to the physician's judgment; however, a physician may not cause a miscarriage after viability except where necessary, in his medical judgment to preserve the life or health of the mother. . . .
>
> We hold that, except as to those cases defined and exempted under *Roe v Wade* and [its companion case] *Doe v Bolton*, . . . criminal responsibility attaches. [*Bricker*, 389 Mich at 529–531.][14]

[14] Similarly, in *Larkin v Cahalan*, 389 Mich 533; 208 NW2d 176 (1973), the Michigan Supreme Court construed MCL 750.323—one of the companion statutes to the Criminal Abortion Ban, the text of which criminalizes abortions provided after the point of "quickening" as manslaughter—as not applying to abortions before viability, in order to preserve that statute's constitutionality under *Roe v Wade*. *Larkin*, 389 Mich at 541–542 ("We hold that the word child as used in [MCL 750.322] means a viable child . . . capable of surviving the trauma of birth . . . ."). As in *Bricker*, the court did not enjoin the statute, but merely declared it constitutional "[a]s interpreted herein." *Id.* at 542. Accordingly, for all the reasons articulated as to MCL 750.14,

Considering both its text and its judicial construction, the Criminal Abortion Ban is unconstitutionally vague for at least two reasons. First, it is unclear whether *Bricker*'s construction of the statute froze in place the protections of *Roe* as the *Bricker* Court then understood them, or whether instead the statute's prohibitions are dynamic, shifting automatically as federal constitutional law shifts over time. Arguably, by authoritatively "constru[ing]" the statute "to mean" that it "shall not apply" to certain conduct, see *Bricker*, 389 Mich at 529–530, the Court rendered the Criminal Abortion Ban permanently inapplicable to any conduct that *Roe* protected as of the *Bricker* decision in 1973. But some state actors may read *Bricker* as incorporating *Roe and its progeny*, and may attempt to enforce the Criminal Abortion Ban against conduct arguably left unprotected by post-*Roe* developments in federal constitutional jurisprudence. Given the decision in *Dobbs*, the scope of the Ban as read in the light of the overruling of *Roe* and *Casey* is ever less clear. The Ban therefore quintessentially fails to provide fair notice of what it proscribes and impermissibly confers discretion on law enforcement to determine whether the law has now sprung into effect and is being violated.

Second, even absent *Bricker*'s federal overlay, it is unclear whether the Criminal Abortion Ban allows abortions to protect a pregnant person's health, or only to preserve their life. On its face, the Ban prohibits abortion in all circumstances except to save a pregnant person's life. MCL 750.14. But *Bricker* recognized an additional exception required by *Roe*, authorizing abortions "necessary, in [the attending physician's] medical judgment to preserve the life or health of the mother." *Bricker*, 389 Mich at 529. It is unclear whether *Bricker*'s health exception, premised on

Plaintiffs also seek declaratory and injunctive relief against enforcement of MCL 750.323, and any other Michigan statute or regulation to the extent it prohibits abortions.

the Michigan Supreme Court's interpretation of *Roe*, remains now that the decision in *Dobbs* eviscerates *Roe*'s protections.[15]

The Criminal Abortion Ban as written is thus unconstitutionally vague, and made worse by *Bricker*'s possible incorporation of *Roe*'s shifting—and now obsolete—federal protections. The statute therefore fails to provide sufficient guidance as to what conduct it proscribes and encourages ad hoc, pretextual or discriminatory application. Its archaic language and framing is no longer capable of construction without ambiguity, and it should be declared unconstitutionally vague.

II. PLAINTIFFS WILL SUFFER IRREPARABLE HARM WITHOUT A PERMANENT INJUNCTION

Permanent injunctive relief is warranted here because justice requires it; there is no adequate remedy at law; and there exists a real and imminent danger of irreparable injury. See *Higgins Lake Property Owners' Ass'n*, 255 Mich App at 106. Unless this Court enters permanent injunctive relief, the very real certainty of prosecution and civil enforcement will force Plaintiffs to cease providing abortions altogether, thus depriving people of access to abortion and forcing many to carry their pregnancies to term against their will. Plaintiffs' patients will suffer irreparable injury from the complete loss of their constitutional rights. See *Elrod v Burns*, 427 US 347, 373; 96 S Ct 2673; 49 L Ed 2d 547 (1976) (holding that in an area of fundamental constitutional rights, the loss of constitutional rights "for even minimal periods of time[] unquestionably constitutes

[15] Similarly, although *Bricker* construed MCL 750.14 as including a health exception, *Larkin*—decided the same day—merely quoted *Roe*'s "life or health of the mother" language without ever stating that it construed MCL 750.323 as including such an exception. *Larkin*, 389 Mich at 541–542. Accordingly, it remains unclear whether MCL 750.323, as construed in *Larkin*, and now without any overriding protections of *Roe*, contains an exception for protecting the pregnant person's health.

irreparable injury"); see also *Roman Catholic Diocese of Brooklyn v Cuomo*, ___ US ___; 141 S Ct 63, 67; 208 L Ed 2d 206 (2020) (per curiam). Indeed, in granting preliminary injunctive relief, this Court has already found a "serious danger of irreparable harm," Op, pp 25–26, based on the facts set forth in Dr. Wallett's affidavit. Those dangers remain.

The danger has now arrived, with the loss of all federal constitutional protections of the right to abortion, and even warnings by prosecutors, including amici before this Court, that providers could be at risk by continuing to provide abortions in their county.[16] This has led to at least one major healthcare system that provides abortion initially asserting that "legal ambiguity" places "physicians and clinical teams at risk of criminal liability," and announcing that they "will follow the guidance of the Michigan 1931 law and only allow pregnancy termination when necessary to preserve the life of the woman,"[17] before reversing course and deciding to continue to provide abortion.[18] And while Intervenors have recognized the scope of this Court's preliminary

[16] See LeBlanc, *What Loss of Roe Means for Women Who Want Abortions in Michigan*, Detroit News (June 24, 2022) (quoting attorney Dave Kallman, attorney for prosecuting attorneys Jarzynka and Becker, as warning, "If I were a doctor and I'm in Kent County or Jackson County or any county with pro-life prosecutors, I wouldn't be performing abortions."). https://www.detroitnews.com/story /news/local/michigan/2022/06/24/michigan-abortion-laws-what-supreme-courtruling-means-roe-v-wade/7625224001/ (accessed June 25, 2022).

[17] *Ruling Adds Confusion to Beaumont-Spectrum System Abortion Access*, Detroit News (June 25, 2022). https://www.detroitnews.com/story/news/local/michigan /2022/06/25/merged-beaumont-spectrum-system-ceo-addresses-abortionaccess/7731815001/ (accessed June 25, 2022).

[18] Christina Hall, *Michigan's Largest Health System Reverses Course on Abortion Stance* (June 26, 2022) <https://www.freep.com/story/news/local/michigan/2022/06/26/michigan-spectrum-beaumont-health-system-reverses-course-abortion-stance/7738499001/> (accessed June 28, 2022).

injunction,[19] they are not in a position to control prosecutors or other law enforcement officials who threaten to enforce the Criminal Abortion Ban in the wake of the *Dobbs* decision.

Additionally, even before the *Dobbs* ruling, public officials in Michigan—and three declared candidates for Michigan Attorney General—asserted that the Criminal Abortion Ban would become fully enforceable, allowing for arrests and prosecutions, when the Supreme Court overruled *Roe v Wade*.[20] Finally, the Criminal Abortion Ban has a statute of limitations of six years, MCL 767.24(10), such that a future attorney general could seek to prosecute a Michigan abortion provider under the Criminal Abortion Ban for conduct that occurred during the current attorney general's term, notwithstanding the current attorney general's unwillingness to enforce the Ban.

Thus, at risk right now, in the absence of this Court issuing a permanent injunction, is the danger of prosecution and civil enforcement that would force Plaintiffs to stop offering virtually all abortions in Michigan. Wallett Aff ¶¶ 3, 13, 73, 75. The danger of enforcement of any other Michigan statute or regulation to prohibit abortion would have the same effect.

Banning abortion in Michigan would have devastating consequences for Plaintiffs and their patients, as well as for Plaintiffs' patients' families and communities. See *id.* ¶¶ 75–85. Many patients would not be able to travel to another state to access abortion, or would be significantly delayed by the cost and logistical arrangements required to do so. *Id.* ¶ 76. Delays in accessing

[19] See Intervenors' Answer, ¶ 95 (acknowledging that "this Court entered a state-wide preliminary injunction on May 17, 2022, prohibiting the Attorney General and all county prosecutors from enforcing MCL 750.14), Ex 1 to Intervenors' June 6, 2022 Mot to Intervene.

[20] Oosting, *A Michigan Abortion Ban Could 'Shock' State Politics Ahead of 2022 Election*, Bridge Mich (February 22, 2022) <https://www.bridgemi.com/michigan-government/ michigan-abortion-ban-could-shock-state-politics-ahead-2022-election> (accessed April 4, 2022).

abortion, or being unable to access abortion at all, pose risks to people's health. *Id.* ¶ 79. And because pregnancy and childbirth are far more medically risky than abortion, forcing people to carry a pregnancy to term exposes them to an increased risk of physical harm. *Id.*; see also *id.* ¶¶ 19–42.

Enforcing the Criminal Abortion Ban as written would most harm people who are poor or have low incomes, people living in rural counties or urban areas without access to adequate prenatal care or obstetrical providers, and would have a disparate impact on Black people in Michigan. *Id.* ¶ 82. Pregnancy and childbirth are more dangerous for Black women than for white women: as of 2020, the national maternal mortality rate for Black women is approximately three times the rate for white women. *Id.* Banning abortion in Michigan would force Black women to bear this disproportionate risk to their health and their lives. *Id.*

Because the Criminal Abortion Ban as written does not allow exceptions for pregnancies resulting from rape or incest, see MCL 750.14, the Ban would have a uniquely devastating impact on rape and incest survivors, who would be forced either to carry their pregnancies to term or to find a way to access abortion in another state. Wallett Aff ¶ 83.

If abortion is criminalized in Michigan, some people will likely self-manage abortion. *Id.* ¶ 84. Some who do may experience one of the rare complications from medication abortion and may be too afraid to seek necessary follow-up care. *Id.*

Given the Criminal Abortion Ban's extraordinarily narrow exception for abortions necessary to preserve the pregnant person's life, pregnant people with dangerous medical conditions may be forced to wait to receive an abortion—even an urgently medically necessary abortion—until they are literally dying. *Id.* ¶ 85.

The Criminal Abortion Ban would also directly harm PPMI's mission and its standing in

the eyes of its patients. *Id.* ¶ 89. Some patients might misunderstand why PPMI is no longer providing abortion and think that it is because its providers no longer want to help them. *Id.* PPMI would no longer be seen as a safe place where people can be open and honest about their health care histories and needs, not only harming PPMI's reputation as a health care provider, but interfering with its ability to provide other care. *Id.* Additionally, some PPMI staff may be afraid to continue working at PPMI if the Criminal Abortion Ban became enforceable. *Id.* ¶ 90.

Finally, enforcing the Criminal Abortion Ban as written would harm Dr. Wallett personally, as her work as an abortion provider is both a core part of her identity and her area of professional expertise. *Id.* ¶ 91. If Dr. Wallett were no longer able to provide abortion in Michigan, she would be forced to choose between staying in state and continuing to provide other medical care to Michigan patients, or uprooting her life and her family and moving to a state where abortion remains legal so that she could use her extensive training to continue to provide this vitally important health care. *Id.* Other abortion providers in Michigan would face this same dilemma. *Id.*

III. THE OTHER PERMANENT INJUNCTION FACTORS SUPPORT THE REQUESTED RELIEF

Plaintiffs seek a declaratory judgment recognizing that banning abortion violates the Michigan Constitution's rights to bodily integrity, equal protection, liberty, and privacy, as well as ELCRA, and that the Criminal Abortion Ban is unconstitutionally vague. In addition to the Criminal Abortion Ban, other Michigan statutes may violate the Michigan Constitution and ELCRA to the extent that they are interpreted to ban abortion before viability, or after viability even where necessary to preserve the patient's life or health. See MCL 750.323 (criminalizing provision of abortion to a "woman pregnant with a quick child" as manslaughter, without a health exception); *Larkin*, 389 Mich at 539–542 (construing "child" as used in MCL 750.323 to mean a viable fetus). Accordingly, Plaintiffs seek a permanent injunction blocking enforcement of MCL

750.14 (the Criminal Abortion Ban), MCL 750.323 (the post-viability ban lacking a health exception), and any other Michigan statute or regulation to the extent that they prohibit abortion before viability, or after viability to preserve the patient's life or health.

As explained above, Plaintiffs and their patients will suffer profound irreparable harm absent permanent injunctive relief. All other permanent injunction factors support relief here, too. First, the "interest[s] to be protected" are of a constitutional magnitude. *Kernan*, 232 Mich App at 514. Second, permanent injunctive relief is necessary to protect Plaintiffs from the risk of investigation and prosecution: given the public vows of multiple candidates for Michigan Attorney General, declaratory relief alone will not shield Plaintiffs from being hauled into court to defend against unlawful prosecutions. *Id*. Third, there has been no "unreasonable delay by the [Plaintiffs] in bringing suit." *Id*. To the contrary, Plaintiffs filed this action just in time to obtain injunctive relief before the United States Supreme Court's decision in *Dobbs*, and they have pressed their case forward at every opportunity. Nor has there been any "related misconduct on the part of the [Plaintiffs]." *Id*.

As to the fifth and sixth *Kernan* factors, this Court has already weighed the relative hardships to the parties and considered the public interest. *Id*. Defendant, the Attorney General of the State of Michigan, will not experience hardship if a permanent injunction is granted. A permanent injunction would align with the expectations, reliance, and actions of people in Michigan for nearly fifty years. Indeed, a permanent injunction benefits all parties by clarifying their rights and obligations under the Criminal Abortion Ban. Cf. *Duke Power Co v Carolina Environmental Study Group, Inc*, 438 US 59, 82; 98 S Ct 2620; 57 L Ed 2d 595 (1978).

The public interest lies with protecting the rights of Michiganders and ensuring the vindication of their civil rights. See *Barczak v Rockwell Int'l Corp*, 68 Mich App 759, 765; 244

NW2d 24 (1976) (finding that a "state . . . ha[s] strong public policies in favor of remedying any violation of an individual's civil rights"); *Liberty Coins, LLC v Goodman*, 748 F3d 682, 690 (CA 6, 2014) (recognizing that it is "always in the public interest to prevent the violation of a party's constitutional rights" (citation omitted)). The public interest is not served by uncertainty regarding Plaintiffs' and their patients' fundamental constitutional rights. Nor would it be served by expending public resources to investigate and prosecute Plaintiffs for providing abortion—safe, common, and essential health care that people in Michigan have relied on for decades.

Finally, framing and enforcing the permanent injunction is eminently practicable. *Kernan*, 232 Mich App at 514. For nearly fifty years, people in Michigan have relied on access to abortion before viability, and after viability to preserve their lives and their health. See *Bricker*, 389 Mich at 529–531. An order permanently enjoining the Criminal Abortion Ban and any other Michigan statute or regulation to the extent that they prohibit abortion in these circumstances would align with the expectations of generations of Michiganders and vindicate the independent force of their "own organic instrument of government." *Sitz*, 443 Mich at 763.

CONCLUSION

For the reasons set forth above, the Court should (1) grant Plaintiffs' motion for summary disposition under MCR 2.116(C)(10), (2) declare that Michigan laws and regulations banning abortion violate the state constitutional rights to bodily integrity, equal protection, liberty, and privacy, as well as the Elliott-Larsen Civil Rights Act, (3) declare that the Criminal Abortion Ban is unconstitutionally vague, and (4) enter a permanent injunction restraining Defendant, her successors, agents, servants, employees, and attorneys, and all persons in active concert or participation with them, including all persons supervised by Defendant, see MCL 14.30, from enforcing or giving effect to MCL 750.14, MCL 750.323, and any other Michigan statute or

regulation to the extent that it prohibits abortions before viability, or after viability when preserving the life or health of the pregnant person.

Respectfully submitted,

/s/ *Deborah LaBelle*

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ATTORNEYS FOR PLAINTIFFS

Dated: June 29, 2022

EXHIBIT 1

STATE OF MICHIGAN
IN THE COURT OF CLAIMS

PLANNED PARENTHOOD OF MICHIGAN, on behalf of itself, its physicians and staff, and its patients; and **SARAH WALLETT, M.D., M.P.H., FACOG**, on her own behalf and on behalf of her patients,

Plaintiffs,

v

ATTORNEY GENERAL OF THE STATE OF MICHIGAN, in her official capacity,

Defendant.
_____/

Case No.

Hon.

AFFIDAVIT OF SARAH WALLETT, M.D., M.P.H., FACOG, IN SUPPORT OF PLAINTIFFS' APRIL 7, 2022 MOTION FOR PRELIMINARY INJUNCTION

I, Sarah Wallett, M.D., M.P.H., FACOG, being duly sworn on oath, do depose and state as follows:

1. I am a board-certified obstetrician-gynecologist licensed in Michigan and the Chief Medical Officer of Planned Parenthood of Michigan (PPMI). Along with PPMI, I am a plaintiff in this case.

2. I went to medical school because I was raised to understand that it was my duty to help people in need. In service of that duty, I began providing abortion to patients in Michigan in 2009, and I continue to do so today. This medical care is life-changing and, in many circumstances, life-saving. Indeed, I believe that providing abortion is the most important thing I will ever do.

3. I understand that a 1931 Michigan statute bans abortion, even in cases of rape, incest, or grave threats to the pregnant person's health. I understand that if this law (the "Criminal Abortion Ban") were enforced as written, I could be criminally prosecuted for providing an

abortion at any point in pregnancy, unless the abortion is necessary to save the pregnant person's life. I understand that the Michigan Supreme Court has said that I cannot be prosecuted for providing pre-viability abortion, but if the Criminal Abortion Ban can be enforced as written, I believe I am at risk of possible prosecution—and at risk of losing my medical license—if I continue to provide abortion to my patients.

4. I understand that the Michigan Supreme Court has discussed this law before and ruled that physicians cannot be prosecuted under the Criminal Abortion Ban because the federal constitution protects the right to choose to terminate a pregnancy, as recognized in *Roe v Wade*. This interpretation is what allows me to provide abortion in Michigan today. But should the United States Supreme Court modify those federal protections—which I understand it may do any day now, in the *Dobbs v Jackson Women's Health Organization* case—the Michigan Supreme Court's decision may no longer protect physicians like me from felony prosecution under the Criminal Abortion Ban.

5. My patients' lives and my own would be profoundly disrupted if the Criminal Abortion Ban were enforced to criminalize abortion in Michigan. So would the lives of other Michigan physicians who provide abortion, and of the staff who assist us in doing so. Accordingly, I submit this affidavit in support of the motion for a preliminary injunction to preserve my patients' access to this essential health care and to protect PPMI, myself, and physicians like me from felony prosecution and other civil and administrative penalties.

6. The facts I state here and the opinions I offer are based on my education, my training, my years of medical practice, my expertise as a doctor and specifically as an abortion provider, my personal knowledge, information obtained through the course of my duties at PPMI, and my familiarity with relevant medical literature and statistical data recognized as reliable in the medical profession.

My Education and Professional Background

7. I graduated from Jefferson Medical College (which has since been renamed Sidney Kimmel Medical College) at Thomas Jefferson University in 2009 and completed my residency in obstetrics and gynecology (OB/GYN) at the University of Michigan Medical School in 2013. After residency, I completed a two-year fellowship in complex family planning at the University of Michigan Medical School. While pursuing this fellowship, I also obtained a Master of Public Health degree from the University of Michigan, focusing specifically on health policy.

8. Following my fellowship, I worked as a professor at the University of Kentucky during the 2015–16 term. I then served as Medical Director at Planned Parenthood of the Greater Memphis Region. When that affiliate merged with another to become Planned Parenthood of Tennessee and North Mississippi, I became the Chief Medical Officer of the newly merged affiliate.

9. I became Chief Medical Officer at PPMI, my current role, in March 2019. I also currently serve as an adjunct clinical assistant professor at the University of Michigan Medical School, training University of Michigan medical students, OB/GYN residents, family medicine residents, family medicine fellows, and OB/GYN fellows on site at PPMI's health centers. Finally, I am the current president of the council of Planned Parenthood affiliate medical directors, which supports medical directors in ensuring high-quality clinical care at Planned Parenthood health centers nationwide.

10. A copy of my *curriculum vitae* is attached as Exhibit A.

Planned Parenthood of Michigan

11. PPMI is a not-for-profit corporation headquartered in Ann Arbor that currently operates 14 health centers across Michigan, in Ann Arbor, Detroit, Ferndale, Flint, Grand Rapids, Jackson, Kalamazoo, Lansing, Livonia, Marquette, Petoskey, Traverse City, and Warren. PPMI or

its predecessors have been operating in Michigan since at least 1922. PPMI is not the only abortion provider in the state; I know that other physicians and hospitals also provide medication abortion and procedural abortion in Michigan.

12. PPMI's health centers provide a wide range of reproductive and sexual health services to patients, including testing and treatment for sexually transmitted infections (STIs), contraception counseling and provision including provision of long-acting reversible contraceptive (LARC) devices, HIV prevention services, pregnancy testing and options counseling, preconception counseling, gynecologic services including menopause care, well-person exams, cervical cancer screening, treatment of abnormal cervical cells, breast cancer screening, colposcopy, miscarriage management, and abortion.

13. PPMI's health centers provide medication abortion through 11 weeks, or 77 days, from the first day of the pregnant person's last menstrual period (LMP). Additionally, PPMI's Ann Arbor East and Kalamazoo health centers provide procedural abortion through 19 weeks, 6 days LMP, and our Flint health center provides procedural abortion through 16 weeks, 6 days LMP. Each of these three health centers is licensed as a Freestanding Outpatient Surgical Facility by the Michigan Department of Licensing and Regulatory Affairs. In Fiscal Year 2020 (October 2019 through September 2020), PPMI provided 8,448 abortions. Of those, 6,626 were medication abortions, and 1,822 were procedural abortions.

14. Michigan law creates multiple obstacles that patients must navigate to access abortion here. For example, patients must receive state-mandated information designed to deter them from deciding to have an abortion, then wait 24 hours before initiating their abortion.[1] Minor patients must obtain either written parental consent or permission from a judge before having an

[1] See MCL 333.17015(3).

abortion.[2] And private insurance and insurance obtained through the health care exchanges under the Affordable Care Act can only cover abortion if the patient's life is endangered (or, for private insurance, if a rider was purchased).[3] As an abortion provider in Michigan, I comply with these requirements because they are mandated by law, but none of the requirements is medically necessary or does anything to make my patients healthier or safer.

15. PPMI employs full-time physicians and part-time physicians, as well as physicians who perform contracted work through arrangements with teaching hospitals and universities. All physicians employed by PPMI currently have admitting privileges at the University of Michigan Hospital in Ann Arbor.

16. As Chief Medical Officer at PPMI, I have clinical, administrative, and managerial responsibilities. On the clinical side, as discussed in more detail below, I provide patients with both medication abortion and procedural abortion. I also provide contraception and contraceptive counseling, STI screening and treatment, and miscarriage management. When a patient presents with a complex contraceptive case or requires certain gynecological procedures such as colposcopy, I provide that care as well.

17. I see abortion patients from Michigan as well as abortion patients who travel to Michigan from other states. Between July 2020 and June 2021, PPMI saw 615 abortion patients who traveled to our health centers from other states—7% of the total number of abortion patients seen in that time period. By comparison, in that same time frame, 3% of the patients PPMI saw for all health care services (including abortion) came from out of state.

18. In addition to caring for patients, as Chief Medical Officer I oversee all clinical care and operations at PPMI. This entails supervising more than 10 physicians; more than 20 clinicians;

[2] MCL 722.903–722.904.
[3] MCL 550.541–550.551.

licensed and non-licensed health center staff; and a rotating set of medical students, residents, and fellows who come to PPMI to complete training in abortion and other health care. I also oversee staff's training, proctoring, and annual assessments of their clinical skills.

Pregnancy Has Significant Medical, Financial, and Personal Consequences

19. To understand why abortion matters, it is important first to understand all the ways in which pregnancy affects a person, both during the pregnancy itself and for years afterward.

20. People experience their pregnancies in a range of different ways. While pregnancy can be a celebratory and joyful event for many families, even an uncomplicated pregnancy challenges a person's entire physiology and stresses most major organs. Pregnancy can also be a period of physical and personal discomfort or even alienation; some pregnant people experience significant mental health challenges. For some, such as pregnant people who are transmasculine, nonbinary, or gender-nonconforming, pregnancy can cause dysphoria, a state of unease or general dissatisfaction with life.

21. Pregnancy and childbirth carry significant medical risk. Maternal mortality is a serious problem in the United States. Although most maternal deaths are preventable, maternal mortality rates in this country are rising.[4] The risk of death associated with childbirth is estimated to be 8.8 deaths per 100,000 live births, and the overall risk of maternal mortality[5] is estimated to

[4] Commonwealth Fund, *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries* (2020), available at <https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries>.

[5] As used in this statistic, "maternal mortality" refers to "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes." Hoyert, *Maternal Mortality Rates in the United States, 2020*, Ctrs for Disease Control & Prevention (CDC), Nat'l Ctr for Health Statistics, Div of Vital Statistics (2022), p 1, available at <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/E-stat-Maternal-Mortality-Rates-2022.pdf>.

be 23.8 deaths per 100,000 live births.[6] For comparison, less than one woman dies for every 100,000 abortion procedures.[7]

22. Women of color, and Black women in particular, face heightened risks of maternal mortality and pregnancy-related complications compared to non-Hispanic white women.[8] This disparity between the maternal mortality rates for women of color and non-Hispanic white women has been exacerbated in the past year.[9] Specifically, recent research found that the maternal mortality rate among non-Hispanic Black women was 3.55 times that of non-Hispanic white women, a dramatic increase from previous analysis.[10] Postpartum cardiomyopathy, preeclampsia, and eclampsia were leading causes of maternal death for non-Hispanic Black women, with mortality rates five times those of non-Hispanic white women with the same conditions.[11] Pregnant and postpartum non-Hispanic Black women were also more than two times more likely than non-Hispanic white women to die of hemorrhage or embolism.[12] The study also found that late maternal deaths—those occurring between six weeks and one year postpartum—were 3.5 times more likely among non-Hispanic Black women than non-Hispanic white women.[13] Postpartum cardiomyopathy was the leading cause of late maternal death among all races, with non-Hispanic Black women having a risk of death six times higher than non-Hispanic white women.[14]

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[6] *Id.*

[7] CDC, *Abortion Surveillance — United States, 2019*, 70 Surveillance Summaries 1, 8 (2021), available at <https://www.cdc.gov/mmwr/volumes/70/ss/pdfs/ss7009a1-H.pdf?>.

[8] Hoyert, *supra* note 5, at 1, 3–4.

[9] *Id.* at 3–4.

[10] MacDorman et al, *Racial and Ethnic Disparities in Maternal Mortality in the United States Using Enhanced Vital Records, 2016–17*, 111 Am J Pub Health 1673, 1673, 1676, 1678 tbl 2 (2021).

[11] *Id.* at 1678 tbl 2.

[12] *Id.*

[13] *Id.* at 1676.

[14] *Id.*

23. Every pregnancy necessarily involves significant physical change. A typical pregnancy generally lasts roughly 40 weeks LMP. During that time, the pregnant person experiences a dramatic increase in blood volume, as well as an increase in heart rate and in the amount of blood pumped with each heartbeat. Due to hormonal changes, the pregnant person's body produces more of the substances that cause blood to clot. The depth of each breath increases as well. The enlarging uterus and hormones produced by the placenta slow the patient's gastrointestinal tract and put pressure on the urinary tract.

24. As a result of these changes and others, pregnant individuals are more prone to blood clots, nausea and vomiting, dyspnea (breathing discomfort), hypertensive disorders, urinary tract infections, and anemia, among other complications.[15] Pregnant individuals are also at greater risk of certain infections.[16] Many of these complications are mild and resolve without the need for medical intervention. Some, however, require evaluation and occasionally urgent or emergent care to preserve the patient's health or save their life.

25. Pregnancy may aggravate preexisting health conditions such as hypertension and other cardiac disease, diabetes, kidney disease, autoimmune disorders, obesity, asthma, and other pulmonary disease. In 2020, approximately 14.6% of Michigan women had asthma;[17] an estimated 32.1% of Michigan women have hypertension, or 27.6% when adjusted for age, based on combined data from 2015 and 2017.[18]

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[15] Bruce et al, *Maternal Morbidity Rates in a Managed Care Population*, 111 Obstetrics & Gynecology 1089, 1092 (2008).

[16] See *id.* at 1091 tbl 1.

[17] Tian, *Prevalence Estimates for Risk Factors and Health Indicators, State of Michigan, Selected Tables, Michigan Behavioral Risk Factor Survey, 2020*, Mich Dep't of Health & Human Servs, Lifecourse Epidemiology & Genomics Div (2021), pp 8, 31 tbls 5, 28, available at <https://www.michigan.gov/documents/mdhhs/2020_BRFS_Tables_736718_7.pdf>.

[18] Mich Dep't of Health & Human Servs, *Estimated Hypertension Prevalence among Michigan Adults (2015 and 2017 Combined)*, p 1, available at https://www.michigan.gov/

26. Other health conditions may arise for the first time during pregnancy, such as preeclampsia, pregnancy-induced hypertension, deep-vein thrombosis, and gestational diabetes. Without adequate treatment, preeclampsia places the pregnant person at significant risk of cerebral hemorrhage (stroke), as well as liver dysfunction or failure, kidney failure, temporary or permanent vision loss, coma, and death. Patients with preeclampsia can also experience eclampsia, characterized by grand mal seizures. Many of these pregnancy-induced conditions are more common later in pregnancy. People who develop a pregnancy-induced medical condition are at higher risk of developing the same condition in a subsequent pregnancy.

27. Sometimes the nausea and vomiting commonly associated with "morning sickness" develops into a syndrome known as hyperemesis gravidarum. Hyperemesis gravidarum is characterized by vomiting so severe that it may result in dangerous weight loss; dehydration; acidosis from starvation; or hypokalemia, a potentially dangerous condition caused by a lack of potassium that can trigger psychosis, delirium, hallucinations, and abnormal heart rhythms, among other things. Pregnant people with this condition may require multiple hospital admissions throughout pregnancy.

28. Many pregnant people seek care in the emergency department at least once during pregnancy. People with comorbidities (including both people with preexisting comorbidities and those who develop comorbidities as a result of their pregnancy), such as asthma, obesity, hypertension, or diabetes, are significantly more likely to seek emergency care.

29. A relatively common complication of pregnancy is ectopic pregnancy, which occurs when a fertilized egg implants anywhere other than in the endometrial lining of the uterus, usually in a fallopian tube. If an ectopic pregnancy ruptures, it can kill the pregnant person;

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documents/mdhhs/HTN_Prevalence_MI_Adults_MI_BRFS_2015-2017_699103_7.pdf (accessed April 4, 2022).

ruptured ectopic pregnancy is a significant cause of pregnancy-related mortality and morbidity, and it is the leading cause of obstetric hemorrhage-related mortality. Ectopic pregnancies can also lead to scarring of the fallopian tube, leading in turn to fertility issues, and can compromise other organs.

30. Every pregnancy also carries a risk of miscarriage, as well as a risk of preterm premature rupture of membranes—in other words, the bag of waters surrounding the pregnancy breaking dangerously early. Complications from miscarriage can lead to infection, hemorrhage,[19] and even death. By comparison, the risk of death following a miscarriage is roughly twice the risk of death following an abortion (the risk of death following abortion is approximately 0.7 deaths per 100,000 procedures).[20]

31. Mental health conditions may emerge for the first time during pregnancy or in the postpartum period.[21] A person with a history of mental illness may also experience a recurrence of their illness, likely as a result of the hormonal and neurochemical changes their body is experiencing, and/or as a result of stress and anxiety relating to the pregnancy.[22] Additionally, a person taking medication to manage a mental health condition may choose to discontinue or modify their medication regimen to avoid risking harm to the fetus—thereby increasing the

[19] Am College Obstetricians & Gynecologists (ACOG), Practice Bulletin No 200, *Early Pregnancy Loss* (Nov 2018), p e201, available at <https://static1.squarespace.com/static/5d3a2e1399c0960001b14452/t/5dc2031df1ffb26c011ff481/1572995870418/ACOG+EPL+Bulletin_update.pdf>.

[20] Nat'l Academies of Sciences, Engineering, & Med, *The Safety & Quality of Abortion Care in the United States* (2018), p 75 tbl 2-4.

[21] Yonkers et al, *Diagnosis, Pathophysiology, and Management of Mood Disorders in Pregnant and Postpartum Women*, 117 Obstetrics & Gynecology 961, 963 (2011); see also Bruce et al, *supra* note 15, at 1093.

[22] Yonkers, *supra* note 21, at 964–67.

likelihood that they will experience a recurrence of their mental illness.[23] Pregnant people with a prior history of mental health conditions also face a heightened risk of postpartum mental illness.[24]

32. Separate from pregnancy, childbirth itself is a significant medical event.[25] Even a normal pregnancy can suddenly become life-threatening during labor and delivery, when 20% of the pregnant person's blood flow is diverted to the uterus. This increased blood flow places the patient at risk of hemorrhage and, in turn, death; indeed, hemorrhage is the leading cause of severe maternal morbidity.[26] As mentioned above, during pregnancy—to try to protect against hemorrhage—the body produces more clotting factors, which increases the pregnant person's risk of developing blood clots or embolisms. This heightened risk of blood clots extends past delivery into the postpartum period.

33. People who undergo labor and delivery can experience other unexpected adverse events such as transfusion, perineal laceration, ruptured uterus, and unexpected hysterectomy.

34. In 2017, approximately 31.9% of Michigan deliveries were by cesarean section (C-section),[27] an open abdominal surgery requiring hospitalization for at least a few days. While common, C-sections carry risks of hemorrhage, infection, and injury to internal organs.

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[23] See, e.g., Diav-Citrin et al, *Pregnancy Outcome Following In Utero Exposure to Lithium: A Prospective, Comparative, Observational Study*, 171 Am J of Psychiatry 785, 789–90 (2014) (finding increased risk of cardiovascular anomalies among lithium-exposed pregnancies).

[24] Marcus, *Depression During Pregnancy: Rates, Risks and Consequences*, 16 J Population Therapeutics & Clinical Pharmacology e15, e18–e19 (2009).

[25] See, e.g., Mich Dep't of Health & Human Servs, Div for Vital Records & Health Statistics, *Number of Live Births by Maternal Morbidity and Onset of Labor by Race and Ancestry of Mother, Michigan Residents, 2020* <https://www.mdch.state.mi.us/osr/natality/MorbidityRaceNo.asp> (accessed April 4, 2022); Mich Dep't of Health & Human Servs, *Overview of Severe Maternal Morbidity in Michigan 2011–2019* (2021), available at <https://www.michigan.gov/documents/mdhhs/SMM_Report_Final_10.5.21_737494_7.pdf>.

[26] ACOG, Practice Bulletin No 183, *Postpartum Hemorrhage*, 130 Obstetrics & Gynecology e168, e168 (2017).

[27] CDC, Nat'l Ctr for Health Statistics, *Stats of the State of Michigan* (April 11, 2018) <https://www.cdc.gov/nchs/pressroom/states/michigan/michigan.htm> (accessed April 4, 2022).

Meanwhile, a vaginal delivery often leads to injury, such as injury to the pelvic floor. This can have long-term consequences, including fecal or urinary incontinence.

35. Pregnancy and childbirth are expensive. Pregnancy-related health care and childbirth are some of the costliest hospital-based health services.[28] On average, vaginal birth costs over $15,300, and a C-section costs over $20,400—and costs can be much higher for complicated or at-risk pregnancies.[29] I am aware of physicians in private practice who routinely help their obstetric patients create payment plans to afford the cost of labor and delivery.

36. While insurance may cover most of these expenses, many pregnant patients with insurance must still pay for significant labor and delivery costs out of pocket. A recent study found that 98% of women on employer-sponsored insurance had to pay out-of-pocket costs from childbirth.[30] Out-of-pocket costs today average around $4,314 for vaginal deliveries and $5,161 for C-sections.[31]

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[28] Allsbrook & Ahmed, *Building on the ACA: Administrative Actions to Improve Maternal Health*, (March 25, 2021), Ctr for Am Progress <https://www.americanprogress.org/article/building-aca-administrative-actions-improve-maternal-health>/ (accessed April 4, 2022), citing Wier & Andrews, Healthcare Cost & Utilization Project, Statistical Brief #107, *The National Hospital Bill: The Most Expensive Conditions by Payer, 2008* (2011), available at <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb107.jsp>.

[29] *Id.*, citing Sonfield, *No One Benefits If Women Lose Coverage for Maternity Care*, Guttmacher Institute (2017), available at <https://www.guttmacher.org/gpr/2017/06/no-one-benefits-if-women-lose-coverage-maternity-care>. Some sources show even higher rates for both vaginal delivery and C-section. See, e.g., Truven Health Analytics, *The Cost of Having a Baby in the United States* (2013), p 6, available at <https://www.nationalpartnership.org/our-work/resources/health-care/maternity/archive/the-cost-of-having-a-baby-in-the-us.pdf> (finding the "average total charges for care with vaginal and cesarean births" among "women and newborns with employer-provided Commercial health insurance" to be "$32,093 and $51,125, respectively").

[30] Moniz et al, *Out-of-Pocket Spending for Maternity Care Among Women with Employer-Based Insurance, 2008-15*, 39 Health Affairs 18, 20 (2020).

[31] *Id.*

37. Of course, the financial burdens of pregnancy and childbirth weigh even more heavily on people without insurance, who are disproportionately people of color,[32] and on people with unintended pregnancies, who may not have sufficient savings to cover pregnancy-related expenses.[33] Almost half of the pregnancies in the U.S. are unintended, and people of color and people with low incomes experience unintended pregnancy at a disproportionately higher rate,[34] in large part due to systemic barriers to contraceptive access.[35] According to the Federal Reserve, nearly 40% of Americans cannot cover an unexpected $400 expense.[36] Roughly 14% of people of reproductive age do not have health insurance,[37] and even more are under-insured, meaning they lack full coverage for needed services[38] and may need to pay out-of-pocket. A costly pregnancy, particularly for people already facing an array of economic hardships, could have long-term and severe impacts on a family's financial security.[39]

38. Pregnant people may also face an increased risk of intimate partner violence. According to the American College of Obstetricians and Gynecologists (ACOG), "the severity of

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[32] Allsbrook & Ahmed, *supra* note 28.

[33] *Id.*

[34] Guttmacher Institute, *Unintended Pregnancy in the United States* (2019), p 1, available at <https://www.guttmacher.org/sites/default/files/factsheet/fb-unintended-pregnancy-us.pdf>.

[35] ACOG, Committee Opinion No 615, *Access to Contraception* (2015), p 5, available at <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2015/01/access-to-contraception.pdf>; Sudhinaraset et al, *Women's Reproductive Rights Policies and Adverse Birth Outcomes: A State-Level Analysis to Assess the Role of Race and Nativity Status*, 59 Am J Preventive Med 787, 788 (2020).

[36] Bd of Governors of the Fed Reserve Sys, *Report on the Economic Well-Being of U.S. Households in 2018 - May 2019* (May 28, 2019), available at <https://www.federalreserve.gov/publications/2019-economic-well-being-of-us-households-in-2018-dealing-with-unexpected-expenses.htm>.

[37] Adam Sonfield, *Uninsured Rate for People of Reproductive Age Ticked up Between 2016 and 2019*, Guttmacher Institute (April 1, 2021), available at <https://www.guttmacher.org/print/article/2021/04/uninsured-rate-people-reproductive-age-ticked-between-2016-and-2019>.

[38] Allsbrook & Ahmed, *supra* note 28.

[39] See *id.*

intimate partner violence may sometimes escalate during pregnancy or the postpartum period,"[40] and "[h]omicide has been reported as a leading cause of maternal mortality, with the majority perpetrated by a current or former intimate partner."[41] According to the U.S. Centers for Disease Control and Prevention (CDC), 36.1% of Michigan women experience contact sexual violence,[42] physical violence, and/or stalking victimization by an intimate partner in their lifetime.[43] An estimated 51.9% of Michigan women—approximately 2,028,000 women—experience psychological aggression from an intimate partner in their lifetime.[44] Women who have experienced intimate partner violence and who give birth after being unable to access a desired abortion will, in many cases, face increased difficulty escaping that relationship.[45]

39. A person carrying a pregnancy to term may also experience post-pregnancy mental health issues. According to a reported systematic review of the literature, the global prevalence of postpartum depression among healthy women without a history of depression and who give birth to healthy full-term infants is about 17%.[46] In 2018, 13.4% of Michigan women reported experiencing symptoms of depression since giving birth.[47] Similarly, a reported systematic review

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[40] ACOG, Committee Opinion No 518, *Intimate Partner Violence* (2012, reaff'd 2019), p 2, available at <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2012/02/intimate-partner-violence.pdf>.

[41] *Id.*

[42] The CDC defines this term as "a combined measure that includes rape, being made to penetrate someone else, sexual coercion, and/or unwanted sexual contact." Smith et al, CDC, Nat'l Ctr for Injury Prevention & Control, *The National Intimate Partner and Sexual Violence Survey, 2010–2012 State Report* (2017), p 19, available at <https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf.>

[43] *Id.* at 128 tbl 5.7.

[44] *Id.* at 134 tbl 5.9.

[45] See Roberts et al, *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 BMC Med 144, 149 (2014).

[46] Shorey et al, *Prevalence and Incidence of Postpartum Depression Among Healthy Mothers: A Systematic Review and Meta-Analysis*, 104 J Psychiatric Research 235, 238 (2013).

[47] Mich Dep't Health & Human Servs, *Pregnancy-Related Depression* (July 2018), p 1, available at <https://www.michigan.gov/documents/mdhhs/Pregnancy_Related_Depression_APPROVED_alt_text_7.18.2018_628203_7.pdf>.

of the literature examining the prevalence of anxiety disorders among postpartum women estimated that approximately 8.5% of postpartum women experience one or more anxiety disorders.[48]

40. Beyond childbirth, raising a child is expensive, both in terms of direct costs and due to lost wages. On average, women experience a large and persistent decline in earnings following the birth of a child, an economic loss that compounds the additional costs associated with raising a child, which typically exceed $9,000 in annual expenses.[49] In Michigan, the cost of child care for a parent with two children in a Michigan child care center is approximately $18,600 a year—exceeding the average annual cost of rent ($9,900) or a mortgage ($15,000).[50]

41. Given the impact of pregnancy and childbirth on a person's mental and physical health, finances, and personal relationships, whether to become or remain pregnant is one of the most personal and consequential decisions a person will make in their lifetime. Certainly, many people decide that adding a child to their family is well worth all of these risks and consequences. But no one should be forced to assume those risks involuntarily. As discussed below, I am gravely concerned that if abortion becomes unavailable in Michigan—as might happen any day now—thousands of pregnant people in this state will be forced to do so.

Background on Abortion

42. Abortion is one of the safest and most common medical services performed in the United States today. Indeed, abortion carries far fewer risks than childbirth. A woman's risk of

[48] Goodman, Watson, & Stubbs, *Anxiety Disorders in Postpartum Women: A Systematic Review and Meta-Analysis,* 203 J of Affective Disorders 292, 328 & tbl 8 (2016).

[49] Miller, Wherry, & Foster, *The Economic Consequences of Being Denied an Abortion*, NBER Working Paper No 26662 (revised January 2022), p 2, available at <https://www.nber.org/system/files/working_papers/w26662/w26662.pdf>.

[50] Mich League for Pub Policy, *2021 Budget Priority: Help Parents with Low Wages Find Affordable Child Care* (2019), p 1, available at <https://mlpp.org/wp-content/uploads/2019/07/2021-budget-priority-child-care-pat.pdf>.

death associated with childbirth, specifically, is more than 12 times higher than that associated with abortion,[51] and the total risk of maternal mortality is 34 times higher than the risk of death associated with abortion.[52] Every pregnancy-related complication is more common among women having live births than among those having abortions.[53] Of the 29,669 induced abortions in Michigan in 2020, the Michigan Department of Health reported just seven immediate complications.[54] The average three-year rate of immediate abortion complications between 2017 and 2019 was 3.5 per 10,000 induced abortions: just 0.035%.[55] Approximately one in four women in this country will have an abortion by age forty-five.[56]

43. There are two general categories of methods used to provide abortion: medication abortion and procedural abortion.[57]

44. For early medication abortion, patients take a regimen of two prescription drugs approved by the U.S. Food and Drug Administration (FDA): mifepristone, which blocks progesterone, a hormone necessary to continue a pregnancy; and misoprostol, which softens the cervix and causes the uterus to contract and empty. Patients first take the mifepristone, then 0 to

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[51] Nat'l Academies of Sciences, Engineering, & Med, *supra* note 20, at 75 tbl. 2-4 (finding a mortality rate of 0.7 per 100,000 procedures for abortion and a mortality rate of 8.8 per 100,000 live births for childbirth).

[52] Hoyert, *supra* note 5, at 1 (finding an overall maternal mortality rate of 23.8 per 100,000 live births).

[53] Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216–17 & fig 1 (2012).

[54] Mich Dep't of Health, Div for Vital Records & Health Stats, *Table 22, Number, Percent and Rate of Reported Induced Abortions with Any Mention of Immediate Complication by Type of Immediate Complication, Michigan Occurrences, 2020* <https://www.mdch.state.mi.us/osr/abortion/Tab_13.asp> (accessed April 4, 2022).

[55] *Id.*

[56] Jones & Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 Am J Pub Health 1904, 1904, 1908 (2017).

[57] The only other medically-proven method of abortion is induction. Induction abortion uses medications to induce labor in a hospital, but accounts for only a small percentage of abortions in the United States.

48 hours later, they take the misoprostol at a location of their choosing, typically at home. Together, the medications cause the pregnancy to pass in a process similar to miscarriage.

45. The use of mifepristone in combination with misoprostol is evidence-based and widely used to terminate pregnancies through 11 weeks (or 77 days) LMP. Accordingly, through 11 weeks LMP, patients wishing to terminate their pregnancies may choose between medication and procedural abortion. After 11 weeks LMP, only procedural abortion is generally available.

46. For procedural abortion, a clinician uses instruments and/or medication to widen the patient's cervical opening and to evacuate the contents of the uterus. Procedural abortion is a straightforward and brief procedure. It is almost always performed in an outpatient setting and sometimes involves local anesthesia or conscious sedation to make the patient more comfortable. Although procedural abortion is sometimes referred to as "surgical abortion," it is not what is commonly understood to be surgery, as it involves no incisions, no need for general anesthesia, and no need for a sterile field.

47. Up to approximately 14 weeks LMP, procedural abortion relies on the aspiration technique, where the clinician inserts a thin, flexible tube through the patient's cervical opening and uses gentle suction to empty the uterus. After approximately 14 weeks LMP, procedural abortion involves the dilation and evacuation (D&E) technique, where the clinician uses instruments as well as aspiration to empty the uterus. Starting around 18 to 20 weeks LMP, an additional procedure may be performed to ensure that the patient's cervix is adequately dilated for the procedural abortion. This may occur on the same day as the abortion, or the day prior to the abortion.

48. As mentioned above, Michigan law creates additional, medically unnecessary steps that we must follow when providing either a medication abortion or a procedural abortion: patients must receive certain state-mandated information at least 24 hours before the abortion, and patients

who are minors must either obtain written parental consent or obtain permission from a judge through a legal proceeding that can take several days to complete.

49. There is no typical abortion patient, and pregnant people seek abortions for a variety of deeply personal reasons. In addition to cisgender women, gender-nonconforming people, transmasculine people, and trans men have abortions.[58] Some people have abortions because they conclude that it is not the right time in their lives to have a child or to add to their families.[59] Some decide to end a pregnancy because they want to pursue their education[60] or because of the negative impact pregnancy would have on their current employment or employment opportunities. Some people have an abortion because they feel they lack the necessary economic resources or an adequate level of family or partner support or stability to parent a child.[61] Some decide to have an abortion because they do not want children at all.[62] Some people decide to end their pregnancy because it is dangerous to their mental or physical health, including by worsening a pre-existing condition or triggering the onset of a new condition.

50. Nearly 60% of abortion patients nationally already have at least one child.[63] Most also report plans to have children (or additional children)[64] at another time in their lives.

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[58] To reflect this reality, in this affidavit I generally use the phrase "pregnant person" rather than "pregnant woman." I occasionally use "woman" or "women" as a short-hand for people who are or may become pregnant, while recognizing that people of all gender identities may become pregnant and seek abortion services. I also use "woman" or "women" when citing or quoting research that reports its results in terms of "women," to preserve the accuracy of those results.

[59] Biggs, Gould, & Foster, *Understanding Why Women Seek Abortions in the US*, 13 BMC Women's Health e1, e5–e8 (2013); Finer et al, *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 Perspectives on Sexual & Reproductive Health 110, 112 (2005).

[60] Biggs, Gould, & Foster, *supra* note 59, at e7; Finer et al, *supra* note 59, at 112.

[61] Biggs, Gould, & Foster, *supra* note 59, at e5–e7; Finer et al, *supra* note 59, at 112.

[62] Biggs, Gould, & Foster, *supra* note 59, at e8.

[63] Jerman, Jones, & Onda, *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Institute (May 2016), p 7, available at <https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf>.

[64] Henshaw & Kost, *Abortion Patients in 1994–1995: Characteristics and Contraceptive Use*, 28 Family Planning Perspectives 140, 144 (1996), available at <https://www.guttmacher.org/sites/

51. At PPMI, between July 2020 and June 2021, 27% of abortion patients had incomes below 101% of the federal poverty level, and an additional 22% had incomes between 100% and 200% of the federal poverty level.[65] In 2020, 200% of the federal poverty level was $25,520 annually for a household of one, and $34,480 annually for a household composed of one parent and one child.[66] The vast majority—93%—of PPMI abortion patients between July 2020 and June 2021 paid for their abortions out of pocket rather than with insurance.

52. Nearly three-fourths of abortion patients say they cannot afford to become a parent or to add to their families, and the same proportion also cites responsibility to other individuals (such as children or elderly parents), or that having a baby would interfere with work and/or school, as their reason for ending their pregnancy.[67]

53. Some people seek abortions because they are experiencing intimate partner violence. Many of these patients fear that carrying the pregnancy to term and giving birth would further tie them to their abusers. In some circumstances, people experiencing intimate partner violence may face additional risk of violence if their partner learns of their pregnancy or desire for an abortion.

54. Some people seek abortions because the pregnancy is the result of rape.

55. Some people decide to have an abortion because of an indication or diagnosis of a fetal medical condition. Some families feel they do not have the resources—financial, medical,

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default/files/pdfs/pubs/journals/2814096.pdf>.

[65] Because 33% of PPMI abortion patients in that time frame did not report their income level, the actual percentages could be even higher.

[66] See US Dep't of Health & Human Servs, Ass't Secretary for Planning & Evaluation, *2020 Poverty Guidelines* <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references/2020-poverty-guidelines> (2020) (listing the federal poverty level for a household of one as $12,760 and for a household of two as $17,240) (accessed April 4, 2022).

[67] Finer et al, *supra* note 59, at 112.

educational, or emotional—to care for a child with special needs, or to do so while providing for the children they already have.

56. Some people decide to have an abortion because of a fetal medical diagnosis that means after delivery the baby would never be healthy enough to go home. While some may decide to carry such a pregnancy through delivery, others may decide that they wish to terminate the pregnancy.

57. Some abortion patients with high-risk pregnancies—because of advanced maternal age or some other underlying medical condition—have complications that lead them to end their pregnancies to preserve their own life or health. Such underlying medical conditions include severe cardiovascular disease, sickle-cell disease, congenital heart disease, severe liver or kidney disease, and autoimmune disease. Complications requiring abortion to save the pregnant person's life or health include eclampsia, ectopic pregnancy, and infection resulting from a preterm premature rupture of membranes.

58. In summary, the decision to terminate a pregnancy is often motivated by a combination of complex and interrelated factors that are intimately tied to the pregnant person's identity, values, culture, religion, mental and physical health, family circumstances, and resources and economic stability. The decision is often made with the support of the person's partners, loved ones, family, friends, and other support networks, including support networks that are religious and spiritual.

My Medical Practice as an Abortion Provider

59. Since the first year of my medical residency in the OB/GYN department at the University of Michigan Medical School, I have provided both medication abortion and procedural

abortion. In fact, I first began my abortion training during my rotation at a Planned Parenthood health center here in Michigan, in 2009.

60. At PPMI, I currently provide medication abortion through 11 weeks LMP and procedural abortion through 19 weeks, 6 days LMP.

61. I came to this work rather deliberately. I attended college knowing that I wanted to become a doctor, and I went to medical school knowing that I wanted to help women. I became an OB/GYN knowing that providing abortions was an integral part of the care that women require and deserve.

62. Still, I had not considered becoming an abortion provider myself until I was actually in medical school. I was raised in a Christian home in Lexington, South Carolina. My family went to church regularly and said prayers before meals, and I grew up understanding that it was my duty to leave the world a better place than I found it. Abortion was something we never talked about at home; I had neither negative nor positive feelings about it. But to fulfill my moral responsibility to help people in need, I knew I wanted to take care of women and people who can become pregnant, so I decided to become an OB/GYN, and I came to Michigan for that training.

63. In medical school, I noticed that some of the people who I worked with and respected took care of abortion patients in a way that stigmatized those patients, and it negatively impacted the care that those patients received. The patients themselves often seemed to feel as though they needed to justify their desire to have an abortion in order to receive the care they deserved. I came to understand that providing abortion with respect and compassion was something I could do to make a significant difference in people's lives, particularly when others would not.

64. Once I had the opportunity to start working for Planned Parenthood, it just felt right. It matched my core values, shaped by my faith and upbringing. I could care for people without judgment, and with respect and compassion. Unlike when I was working in other settings, at Planned Parenthood I did not have to justify to anyone why providing abortion is important.

65. Today, abortion constitutes the majority of the clinical care I provide—not because I could not provide other care, but because the need for abortion providers is so great.

66. The patients I see every day are so clearly people in need, and the compassion and empathy I learned from my faith are fundamental to my work. I am proud to provide abortion to people in Michigan, and to train other medical students, residents, and fellows to provide compassionate, respectful, high-quality abortion services.

67. Providing abortion in Michigan is both similar to and different from providing abortion in other parts of the country. At PPMI, I see abortion patients who travel to Michigan from other states, most commonly Ohio and Indiana, but also from Wisconsin. We do not affirmatively ask out-of-state patients why they have come to Michigan to obtain an abortion, but sometimes people volunteer that one of our PPMI health centers was the closest access point for them. Others explain that in their home state, they would have been required to make two separate trips to the health center, and that traveling a farther distance one time was less difficult than making two separate trips in their home state. Recently, I even saw a patient from Texas, who came all the way to Michigan after Texas effectively outlawed abortion after approximately six weeks' gestation through its S.B. 8 law.

68. Michigan has significant barriers to abortion access, most notably travel obstacles: in many parts of the state, people have to drive hours to reach a health center that provides abortion. In the Upper Peninsula, there is only one PPMI health center, and it only provides medication

abortion—meaning patients who are past 11 weeks LMP cannot access abortion there at all. Additionally, in Michigan we do not have a robust public-transportation network. Even in metro Detroit, where there are a number of abortion providers, you could be just as out of luck as in rural parts of the state, because without a personal vehicle or a comprehensive bus system, there is no way for someone to get where they need to be.

69. People who are able to access abortion in Michigan frequently still contend with abortion stigma. For example, in parts of the state without a supportive medical community, I worry all the time that other medical providers will not be kind to our patients in the event that they need follow-up care. Worse, I worry that some of our patients will be scared away from seeking needed medical care at all. We already see this with some of our rural patients—in the rare event that someone needs follow-up care after an abortion, they would rather drive a long distance to see us at PPMI than obtain that care closer to home, simply because they do not want anyone closer to home to know that they have terminated a pregnancy.

70. Of course, what abortion ultimately means for patients is the same no matter where they live. Abortion allows people to have control over their bodies and their futures. It makes it possible for them to care for the families they already have, or to escape a dangerous situation in their own home. It alleviates serious medical risks caused or worsened by pregnancy. It brings peace to people who experience pregnancy as a violation of their truest selves. Put simply, abortion is a life-changing and often life-saving procedure that can be and often is positive, not just for patients but also for their loved ones and their communities.

The Consequences of Banning Abortion in Michigan

71. Though I and other PPMI physicians provide abortion that is outlawed by the text of the Criminal Abortion Ban presently on the books, I understand that a Michigan Supreme Court

decision currently protects me and other abortion providers from being criminally prosecuted under that statute. Still, that protection could disappear any day now, since the United States Supreme Court's decision in the *Dobbs v Jackson Women's Health Organization* case could modify *Roe v Wade*—the case on which the Michigan Supreme Court decision relies.

72. I am not a lawyer, but I know that people seeking abortion in Michigan will be confused and panicked if the law changes and if the Criminal Abortion Ban becomes enforceable, outlawing abortion in the state. My patients will not know whether they can still come to PPMI for care, or whether they need to try to make arrangements to travel out of state. This uncertainty will disrupt our ability to care for our patients even before any government official takes a step to enforce the Ban.

73. In addition to the risk of criminal prosecution, I understand that the Michigan Department of Licensing and Regulatory Affairs could revoke my medical license for providing an abortion in violation of the Criminal Abortion Ban as written.[68] And the insurance company that provides my medical malpractice insurance might cancel my coverage even before the licensing action was finalized.[69] Without my medical license or malpractice insurance, I would no longer be able to provide *any* medical care in Michigan.

74. Furthermore, certain parts of the Criminal Abortion Ban as written are unclear to me, as the statute uses certain terms in a way that is inconsistent with medical terminology. For example, I understand that the law makes it a felony to "procure [a] miscarriage." In medical practice, "miscarriage" is used interchangeably with the terms "spontaneous abortion" and "early

[68] Kaffer, *Opinion: Prosecution Wouldn't Be Only Option for Abortion Foes in a Post*-Roe *Michigan*, Detroit Free Press (March 26, 2022) <https://www.freep.com/story/opinion/columnists/nancy-kaffer/2022/03/26/roe-abortion-supreme-court-michigan/7146616001/> (accessed April 4, 2022).

[69] *Id.*

pregnancy loss," and generally refers to "a nonviable, intrauterine pregnancy with either an empty gestational sac or a gestational sac containing an embryo or fetus without fetal heart activity."[70] Because "miscarriage" is something that happens spontaneously, medical professionals would not describe abortion as "procuring a miscarriage."[71] Moreover, I am aware that in Michigan and elsewhere, people who lack a complete or accurate understanding of reproductive medicine may interpret the Criminal Abortion Ban to criminalize conduct that is not abortion at all, such as prescribing emergency contraception.[72]

75. If the Criminal Abortion Ban were enforced as written in Michigan, my colleagues at PPMI and I would be forced to stop providing abortion under virtually any circumstance—that, or face felony prosecution and licensure penalties. In turn, PPMI would no longer be able to offer abortion at its health centers. The Ban would thus have devastating consequences for my patients, for PPMI, and for me personally.

76. If abortion were unavailable in Michigan, many people would not be able to travel to another state to access abortion, or would be significantly delayed by the cost and logistical arrangements required to do so. Already, people living in poverty forgo or delay other basic needs, like rent or groceries, to pay for their abortions and all the associated logistical expenses, such as travel costs, childcare, and time away from work. Many people need to borrow money from family

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[70] ACOG, Practice Bulletin No 200, *supra* note 19, at e197.

[71] See generally *id.*

[72] E.g., Reilly, *Missouri Lawmakers Pretended IUDs Cause Abortion. They Lost*, ReWire News Grp (June 28, 2021) <https://rewirenewsgroup.com/article/2021/06/28/missouri-lawmakers-pretended-iuds-cause-abortion-they-lost/> (accessed April 4, 2022) (Missouri legislators incorrectly characterizing emergency contraception and IUDs as abortion); Filipovic, *How Ohio Became One of the Worst States for Reproductive Rights in the Country*, Cosmopolitan (June 6, 2014) <https://www.cosmopolitan.com/politics/news/a7129/ohio-abortion-laws/> (accessed April 4, 2022) (same in Ohio); Verlee, *Colorado Debates Whether IUDs Are Contraception or Abortion*, Nat'l Pub Radio (March 5, 2015) <https://www.npr.org/sections/health-shots/2015/03/05/391030821/colorado-debates-whether-iuds-are-contraception-or-abortion> (accessed April 4, 2022) (same in Colorado).

and friends to pay for care, which takes time. Navigating inflexible or unpredictable work schedules and child care needs further delays or prevents our patients accessing care.

77. On top of these existing obstacles, many people traveling long distances to an abortion appointment out of state would need to raise additional money to afford the travel. Many would also need to arrange for childcare and time off work while they are away. The need to travel could thus significantly delay people in accessing care. And because abortion becomes more expensive as pregnancy progresses, people trying to save money for an abortion, plus money to pay for the necessary travel out of state, could find themselves in a vicious cycle: as the process of raising the necessary funds delays them in obtaining care, the amount of money required grows, resulting in more delay. This delay could, in turn, push some people past the point in pregnancy where abortion is legally or practically available in nearby states, forcing them to carry the pregnancy to term against their will.

78. I am mindful that, currently, people travel to Michigan for an abortion because for some it is easier to access abortion here than in surrounding states. If abortion were illegal in Michigan, I worry that both people from Michigan and people from those other states would be unable to access abortion at all.

79. Delays in accessing abortion, or being unable to access abortion at all, pose risks to patients' health. While abortion is very safe at any point in pregnancy, the risks of abortion increase with gestational age.[73] And because pregnancy and childbirth are far more medically risky than abortion, forcing people to carry a pregnancy to term exposes them to an increased risk of physical harm. If abortion is no longer available, people will instead be forced to remain pregnant and give

[73] Nat'l Academies of Sciences, Engineering, & Med, *supra* note 20, at 77–78, 163 & tbl 5-1.

birth in a health care system that does not adequately keep pregnant people safe, especially pregnant people of color.

80. Further, a person's ability to access abortion has consequences not only for that person, but also for their family and community. Longitudinal research assessing the short- and long-term consequences of being denied an abortion demonstrates the negative impacts not only on the person's mental health,[74] on their professional prospects,[75] and on their finances,[76] but also on the well-being of their existing children[77] and of the child the person is forced to have.[78]

81. The COVID-19 pandemic has exacerbated these consequences, as access to affordable child care has been strained and women have been forced out of the workforce to care for children at rates vastly disproportionate to men. Since the start of the pandemic, women have lost a net five million jobs, and 2.3 million women have left the workforce entirely, likely as a result of child care obligations.[79]

82. Enforcing the Criminal Abortion Ban would most harm pregnant people who are poor or have low incomes, pregnant people living in rural counties or urban areas without access

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[74] Biggs et al, *Women's Mental Health and Well-being 5 Years After Receiving or Being Denied an Abortion*, J Am Med Ass'n Psychiatry E1, E3–E6 (2017).

[75] Upadhyay, Biggs, & Foster, *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15 BMC Women's Health e1, e4, e6 (2015).

[76] Miller, Wherry, & Foster, *supra* note 49, at 36.

[77] Foster et al, *Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children*, 205 J of Pediatrics 183, 185, 187 (2019); see also Foster et al, *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 Am J Pub Health 407, 411–12 (2018) (finding that denial of a wanted abortion exacerbates socioeconomic hardships).

[78] Foster et al, *Comparison of Health, Development, Maternal Bonding, and Poverty Among Children Born After Denial of Abortion vs After Pregnancies Subsequent to An Abortion*, 172 J Am Med Ass'n 1053, 1056–59 (2018); see also Foster et al, *Socioeconomic Outcomes of Women*, *supra* note 77, at 411–12.

[79] Nat'l Women's Law Ctr, *A Lifetime's Worth of Benefits: The Effects of Affordable, High-Quality Child Care on Family Income, the Gender Earnings Gap, and Women's Retirement Security* (2021), p 1, available at <https://nwlc.org/wp-content/uploads/2021/04/Lifetime-Fact-Sheet.pdf>.

to adequate prenatal care or obstetrical providers, and Black pregnant people in Michigan. Nationwide, three out of four abortion patients are poor or live on low incomes (up to 200% of the federal poverty level).[80] A majority of people in Michigan who had an abortion in 2020 identified as Black;[81] in Michigan and nationally, Black patients seek abortions at a higher rate than white patients due to disparities caused by a long history of structural racism—specifically, unequal access to quality family-planning services, economic disadvantage,[82] and other social determinants of health such as limited access to "safe and affordable housing, quality education, healthy food, [and] stable employment."[83] As discussed above, pregnancy is more dangerous for Black women than it is for white women: as of 2020, the national maternal mortality rate for Black women is approximately three times the rate for white women,[84] a consequence of structural and systemic racism. Banning abortion in Michigan would force Black women to bear this disproportionate risk to their health and their lives.

83. Because the Criminal Abortion Ban does not allow exceptions for pregnancies resulting from rape or incest, it would have a uniquely devastating impact on survivors of those crimes, who would be forced either to carry the pregnancy to term or to find a way to access abortion in another state.

84. If abortion were outlawed in Michigan, given the barriers to accessing abortion out of state, I expect that some people would find ways to self-manage abortion. Some who do may

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[80] Jerman, Jones, & Onda, *supra* note 63, at 11.

[81] Mich Dep't of Community Health, *Table 11, Number and Percent of Reported Induced Abortions by Race or Hispanic Ancestry of Woman, Michigan Residents, 2020* <https://www.mdch.state.mi.us/osr/abortion/Abortrace.asp> (accessed April 4, 2022).

[82] CDC, *Abortion Surveillance — United States*, *supra* note 7, at 7.

[83] Mich Dep't of Health & Human Servs, *2020 Health Equity Report, Moving Health Equity Forward*, p 4 (2021), available at <https://www.michigan.gov/documents/mdhhs/2020_PA653-Health_Equity_Report_Full_731810_7.pdf>.

[84] Hoyert, *supra* note 8, at 1, 3–4.

experience one of the rare complications from medication abortion. As I described earlier, people in Michigan are already afraid to tell their doctors that they have had a *legal* abortion, and I am deeply concerned that, if the Criminal Abortion Ban is enforced, people who experience complications after self-managing their abortions will be too afraid to seek necessary follow-up care. Those people could be seriously harmed—not because abortion is unsafe, but because the Criminal Abortion Ban has made it unsafe for them to be fully open with their medical providers and prevented them from accessing accurate medical information.

85. Given the Criminal Abortion Ban's extraordinarily narrow exception for abortions necessary to preserve the pregnant person's life, I fear that pregnant people with dangerous medical conditions will be forced to wait to receive an abortion—even an urgently medically necessary abortion—until they are literally dying. I understand that this is already happening in Texas, where emergency-room physicians are afraid to terminate patients' pregnancies even where doing so would avert serious medical risk to the patient because they are afraid of being sued for violating Texas's law banning abortion at roughly six weeks.[85]

86. I recently had a glimpse of what this world might look like when I saw a patient whose pregnancy was past the legal gestational age limit for abortion in Michigan. When I told this patient that I was not able to provide her an abortion, she sobbed in a way I had not heard in a very long time. She did not want to be pregnant, she was not prepared to decide between parenting and adoption, and traveling out of state was not an option. She left my office with resources, but I felt helpless.

[85] Nat'l Pub Radio, *Doctors' Worst Fears About the Texas Abortion Law Are Coming True* (March 1, 2022) <https://www.npr.org/2022/02/28/1083536401/texas-abortion-law-6-months> (accessed April 4, 2022).

87. If I could not provide abortion in Michigan, that is how I would feel with every single patient. Over and over again, I would have to deliver news that would change someone's entire life against their wishes. Despite knowing that I have the resources and the medical training to help them safely, I would have to tell each person *I'm sorry, I can't help you, because it is a crime for me to provide you with the medical care that you need.*

88. Absent enforcement of the Criminal Abortion Ban, PPMI will continue to provide both medication and procedural abortion in Michigan. But if the Criminal Abortion Ban were enforced against physicians who provide abortion in Michigan, PPMI would be forced to stop offering abortion to our patients.

89. The Criminal Abortion Ban would directly harm PPMI's mission to provide comprehensive sexual and reproductive health care to the communities we serve, and PPMI's standing in the eyes of our patients and supporters. Our patients know PPMI as a trusted, nonjudgmental provider. People trust us with their most personal information and questions, and that allows us to provide the highest-quality sexual and reproductive health care. But if we could no longer provide abortion when people come to us and ask for that care, some patients might misunderstand why we are no longer providing abortion and think that it is because we no longer want to. That would badly undermine our patients' trust in us. People might be afraid to tell us that they have self-managed abortion or that they are planning to travel out of state to obtain abortion elsewhere. We would no longer be seen as a safe place where people can be open and honest about their health care histories and needs. This would not only harm our reputation as a health care provider; it would interfere with our ability to provide other care.

90. Additionally, I worry that some PPMI staff would be afraid to continue working at PPMI if the Criminal Abortion Ban were being enforced against abortion providers. Even if we all

complied with the law, a prosecutor somewhere might accuse us of violating it, or open an invasive investigation into PPMI's practices. Some staff might prefer to leave PPMI rather than continue working with those threats hanging over them. Other staff might simply be unable to bear turning patients away in their time of need, over and over again.

91. Finally, enforcing the Criminal Abortion Ban would harm me personally. My work as an abortion provider is a core part of my identity. It is also my area of professional expertise. If I were no longer able to provide abortion in Michigan, I would face the hard choice between staying here and continuing to provide other medical care to Michigan patients, or uprooting my life and my family and moving to a state where abortion remains legal so that I could use my extensive training to continue to provide this vitally important health care. If I stayed in Michigan, I would be forced to stop providing the specific category of medical care that I am trained in and highly skilled at, and I would not be allowed to provide the care that my patients need. It would feel unethical and immoral to deny my patients medical care that they need and that I am highly trained to provide safely. I would find it challenging to provide any other OB/GYN care in such an environment. Other abortion providers in Michigan would face this same choice, and I know that some are already weighing their options. I am also concerned that medical students and residents in Michigan would no longer be able to learn this critical component of medical care for pregnant people. It makes me so sad to contemplate all that collective medical expertise leaving the state, all because our specialized area of practice—care that today we provide safely and routinely, when and where patients need it—would have become illegal.

92. Not knowing when or how the law will change makes it hard for PPMI to plan even a month in advance. For example, while we try to see people for their abortion appointments as soon as the patient is firm in their decision and available, at some of our health centers we must

schedule appointments two to three weeks in advance. If the Criminal Abortion Ban became enforceable next week, I would need guidance on whether that would prevent me from providing abortions entirely, whether it would only prohibit some of the procedures I provide, or something else entirely. In the absence of that clarity, I would have no idea whether I could care for the patients whose appointments are already scheduled for that week or the week after. And when other PPMI physicians and staff ask about the clinical schedule for the months ahead, I do not know what to tell them. I do not know whether we will still be able to provide abortion a month from now, because I do not know when or even whether the existing legal protections for abortion will disappear. Because it is my personal and professional mission to provide safe, compassionate, high-quality care to my patients, of which abortion is an essential part, this uncertainty keeps me up at night.

FURTHER AFFIANT SAYETH NAUGHT.

STATE OF MICHIGAN)
)ss
COUNTY OF WASHTENAW)

I declare that the above statements set forth in this affidavit are true to the best of my knowledge, information, and belief. If sworn as a witness, I can testify competently to the facts stated herein.

Sarah Wallett, M.D., M.P.H., FACOG

Subscribed and sworn before me this
5th day of April, 2022.

Signed: _____
Printed name: Betsy Lee Lewis, Notary Public
Ingham Co., MI, Acting in Washtenaw Co., MI
My Commission Expires: 01/23/2027

BETSY LEE LEWIS
Notary Public - State of Michigan
County of Ingham
My Commission Expires Jan 23, 2027
Acting in the County of Washtenaw