# ORIGINAL

## IN THE SUPREME COURT OF THE STATE OF OKLAHOMA

OKLAHOMA CALL FOR REPRODUCTIVE JUSTICE, on behalf of itself and its members; TULSA WOMEN'S REPRODUCTIVE CLINIC, LLC, on behalf of itself, its physicians, its staff, and its patients; ALAN BRAID, M.D., on behalf of himself and his patients; COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, INC., on behalf of itself, its physicians, its staff, and its patients; and PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, on behalf of itself, its physicians, its staff, and its patients,

Plaintiffs/Appellants,

v.

JOHN O'CONNOR, in his official capacity as Attorney General for the State of Oklahoma; DAVID PRATER, in his official capacity as District Attorney for Oklahoma County; STEVE KUNZWEILER, in his official capacity as District Attorney for Tulsa County; LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; KATIE TEMPLETON, in her official capacity as President of the Oklahoma State Board of Osteopathic Examiners; LANCE FRYE, in his official capacity as the Commissioner of the Oklahoma State Board of Health; and JUSTIN WILSON, in his official capacity as the President of the Oklahoma State Board of Pharmacy; as well as their employees, agents, and successors,

Defendants/Appellees.



Supreme Court No. 119918



**SUPPLEMENT TO PLAINTIFFS-APPELLANTS' EMERGENCY MOTION FOR A TEMPORARY INJUNCTION PENDING APPEAL TO PRESERVE THE STATUS QUO**

**IN THE SUPREME COURT OF THE STATE OF OKLAHOMA**

OKLAHOMA CALL FOR REPRODUCTIVE JUSTICE, on behalf of itself and its members; TULSA WOMEN'S REPRODUCTIVE CLINIC, LLC, on behalf of itself, its physicians, its staff, and its patients; ALAN BRAID, M.D., on behalf of himself and his patients; COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, INC., on behalf of itself, its physicians, its staff, and its patients; and PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, on behalf of itself, its physicians, its staff, and its patients,

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Dated: October 14, 2021

Submitted by:

J. Blake Patton, Oklahoma Bar No. 30673

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## CERTIFICATE OF SERVICE

I, Blake Patton, hereby certify that on this 14th day of October, 2021, a true and correct copy of the foregoing was delivered to the following:

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Solicitor General
Zach West
Assistant Solicitor General
Devan A. Pederson
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Oklahoma City, Oklahoma 73105
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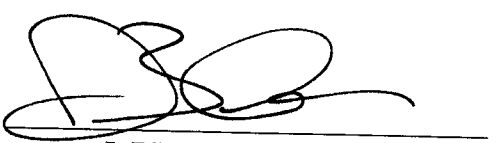

J. BLAKE PATTON

# An Act

ENROLLED HOUSE
BILL NO. 1904

By: Roe, Mize, Townley, Stark, Dills, Hill, Hasenbeck, Nollan, Moore, Newton, Roberts (Sean), Martinez, Miller, Boatman, Caldwell (Trey), Steagall, Wolfley, Lawson, Echols, Manger and Conley of the House

and

Garvin, Bergstrom and Jett of the Senate

An Act relating to public health; amending 63 O.S. 2011, Section 1-731, which relates to persons who may perform abortions; requiring that certain physicians specialize in certain fields; and providing an effective date.

SUBJECT: Public health

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY 63 O.S. 2011, Section 1-731, is amended to read as follows:

Section 1-731. A. No person shall perform or induce an abortion upon a pregnant woman unless that person is a physician licensed to practice medicine in the State of Oklahoma who is board-certified in obstetrics and gynecology. Any person violating this section shall be guilty of a felony punishable by imprisonment for not less than one (1) year nor more than three (3) years in the ~~State Penitentiary~~ custody of the Department of Corrections.

B. No person shall perform or induce an abortion upon a pregnant woman subsequent to the end of the first trimester of her

pregnancy, unless such abortion is performed or induced in a general hospital.

SECTION 2. This act shall become effective November 1, 2021.

Passed the House of Representatives the 2nd day of March, 2021.

_____
Presiding Officer of the House
of Representatives

Passed the Senate the 20th day of April, 2021.

_____
Presiding Officer of the Senate

OFFICE OF THE GOVERNOR

Received by the Office of the Governor this _____

day of _____, 20_____, at _____ o'clock _____ M.

By: _____

Approved by the Governor of the State of Oklahoma this _____

day of _____, 20_____, at _____ o'clock _____ M.

_____
Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Office of the Secretary of State this _____

day of _____, 20_____, at _____ o'clock _____ M.

By: _____

# An Act

ENROLLED SENATE
BILL NO. 778

By: Daniels, Bullard, Stephens, David, Rogers, Taylor, Jett and Bergstrom of the Senate

and

Lepak, Dills, Gann, Smith, Manger, Steagall, West (Kevin), Patzkowsky, Russ and Roberts (Sean) of the House

An Act relating to abortion; creating the Oklahoma Abortion-Inducing Drug Risk Protocol Act; defining terms; limiting provision of abortion-inducing drugs to certain practitioners and procedures; prohibiting provision through certain methods; requiring certain examination; stating criteria of examination; providing for complication management; requiring scheduling and certain efforts of follow-up visit; prohibiting provision of abortion-inducing drugs in certain locations; requiring informed consent within certain time period except under specified conditions; directing use of certain form; stating criteria of valid form; stating additional criteria; requiring State Board of Medical Licensure and Supervision to publish and update certain materials; requiring qualified physician to provide certain information; requiring completion and submission of certain report; stating required inclusions and exclusions of report; requiring certain reporting of adverse event; stating criteria of report; requiring Department to prepare and submit certain report; deeming reports public records; prohibiting certain actions relating to identity of woman; directing reports to be made available to certain entities; requiring Department to communicate reporting requirements; specifying additional reporting

requirements; requiring Department to create and distribute certain forms; providing criminal penalties; providing for certain civil remedies, disciplinary sanctions and injunctive relief; specifying certain judicial procedures; providing certain construction and intent; authorizing certain intervention; providing severability; providing for codification; and providing an effective date.

SUBJECT: Abortion

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-756.1 of Title 63, unless there is created a duplication in numbering, reads as follows:

This act shall be known and may be cited as the "Oklahoma Abortion-Inducing Drug Risk Protocol Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-756.2 of Title 63, unless there is created a duplication in numbering, reads as follows:

As used in this act:

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

2. "Abortion-inducing drug" means a medicine, drug or any other substance prescribed or dispensed with the intent of terminating the pregnancy of a woman known to be pregnant, with knowledge that the

termination will with reasonable likelihood cause the death of the unborn child. This includes the off-label use of drugs known to have abortion-inducing properties, which are prescribed specifically with the intent of causing an abortion, such as mifepristone (Mifeprex), misoprostol (Cytotec) and methotrexate. This definition does not apply to drugs that may be known to cause an abortion, but which are prescribed for other medical indications, such as chemotherapeutic agents and diagnostic drugs. The use of such drugs to induce abortion is also known as "medical", "medication", "RU-486", "chemical", "Mifeprex regimen" or "drug-induced" abortion;

3. "Adverse Event", according to the Food and Drug Administration, means any untoward medical occurrence associated with the use of a drug in humans, whether or not considered drug-related. It does not include an adverse event or suspected adverse reaction that, had it occurred in a more severe form, might have caused death;

4. "Associated physician" means a person licensed to practice medicine in the state including medical doctors and doctors of osteopathy, that has entered into an associated physician agreement;

5. "Complication" means any adverse physical or psychological condition arising from the performance of an abortion which includes, but is not limited to, uterine perforation, cervical perforation, infection, heavy or uncontrolled bleeding, hemorrhage, blood clots resulting in pulmonary embolism or deep vein thrombosis, failure to actually terminate the pregnancy, incomplete abortion (retained tissue), pelvic inflammatory disease, endometritis, missed ectopic pregnancy, cardiac arrest, respiratory arrest, renal failure, metabolic disorder, shock, embolism, coma, placenta previa in subsequent pregnancies, preterm delivery in subsequent pregnancies, free fluid in the abdomen, hemolytic reaction due to the administration of ABO-incompatible blood or blood products, adverse reactions to anesthesia and other drugs, subsequent development of breast cancer, psychological complications such as depression, suicidal ideation, anxiety, sleeping disorders, death and any other adverse event as defined by the Food and Drug Administration criteria provided in the Medwatch Reporting System;

6. "Gestational age" means the time that has elapsed since the first day of the woman's last menstrual period, also known as "last menstrual period" or "LMP";

7. "Hospital" means an institution providing medical and surgical treatment and nursing care for sick or injured people, or institutions defined under Section 1-701 of Title 63 of the Oklahoma Statutes;

8. "Physician" means any person licensed to practice medicine in this state. The term includes medical doctors and doctors of osteopathy;

9. "Pregnant" or "pregnancy" means that female reproductive condition of having an unborn child in the mother's uterus;

10. "Provide" or "provision" means, when used regarding abortion-inducing drugs, any act of giving, selling, dispensing, administering, transferring possession to or otherwise providing or prescribing an abortion-inducing drug;

11. "Qualified physician" means a physician licensed in this state who has the ability to:

a. identify and document a viable intrauterine pregnancy,

b. assess the gestational age of pregnancy and to inform the patient of gestational age-specific risks,

c. diagnose ectopic pregnancy,

d. determine blood type and administer RhoGAM if a woman is Rh negative,

e. assess for signs of domestic abuse, reproductive control, human trafficking and other signals of coerced abortion,

f. provide surgical intervention or has entered into a contract with another qualified physician to provide surgical intervention, and

g. supervise and bear legal responsibility for any agent, employee or contractor who is participating in any part of procedure including, but not limited to, pre-procedure evaluation and care;

12. "Reasonable medical judgment" means a medical judgment that would be made by a reasonably prudent physician knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved; and

13. "Unborn child" means an individual organism of the species homo sapiens, beginning at fertilization, until the point of being born-alive as defined in Title 1 U.S.C., Section 8(b).

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-756.3 of Title 63, unless there is created a duplication in numbering, reads as follows:

Abortion-inducing drugs shall only be provided by a qualified physician following procedures laid out in this act. It shall be unlawful for any manufacturer, supplier, physician, qualified physician or any other person to provide any abortion-inducing drug via courier, delivery or mail service.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-756.4 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The qualified physician providing an abortion-inducing drug shall examine the woman in person, and prior to providing an abortion-inducing drug, shall:

1. Independently verify that a pregnancy exists;

2. Determine the woman's blood type, and if she is Rh negative, be able to and offer to administer RhoGAM at the time of the abortion;

3. Inform the patient that she may see the remains of her unborn child in the process of completing the abortion; and

4. Document, in the woman's medical chart, the gestational age and intrauterine location of the pregnancy, and whether she received treatment for Rh negativity, as diagnosed by the most accurate standard of medical care.

B. A qualified physician providing an abortion-inducing drug shall be credentialed and competent to handle complication management including emergency transfer, or shall have a signed contract with an associated physician who is credentialed to handle complications and be able to produce that signed contract on demand by the pregnant woman, by the State Board of Medical Licensure and Supervision or by the State Department of Health. Every pregnant woman to whom a qualified physician provides any abortion-inducing drug shall be given the name and phone number of the associated physician.

C. The qualified physician providing any abortion-inducing drug or an agent of the qualified physician shall schedule a follow-up visit for the woman at approximately seven (7) to fourteen (14) days after administration of the abortion-inducing drug to confirm that the pregnancy is completely terminated and to assess the degree of bleeding. The qualified physician shall make all reasonable efforts to ensure that the woman returns for the scheduled appointment. A brief description of the efforts made to comply with this subsection including the date, time and identification by name of the person making such efforts, shall be included in the woman's medical record.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-756.5 of Title 63, unless there is created a duplication in numbering, reads as follows:

Notwithstanding any other provision of this act or the laws of this state, abortion-inducing drugs shall not be provided in any school facility or on state grounds including, but not limited to, elementary, secondary and institutions of higher education in this state.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-756.6 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. No abortion-inducing drug shall be provided without the informed consent of the pregnant woman as described in this section to whom the abortion-inducing drug is provided.

B. Informed consent to a chemical abortion shall be obtained at least seventy-two (72) hours before the abortion-inducing drug is provided to the pregnant woman, except if in reasonable medical judgment, compliance with this subsection would pose a greater risk of:

1. The death of the pregnant woman; or

2. The substantial and irreversible physical impairment of a major bodily function not including psychological or emotional conditions, of the pregnant woman.

C. A form created by the State Department of Health shall be used by a qualified physician to obtain the consent required prior to providing an abortion-inducing drug.

D. A consent form is not valid and consent is not sufficient, unless:

1. The patient initials each entry, list, description or declaration required to be on the consent form as detailed in paragraphs 1 through 6 of subsection E of this section;

2. The patient signs the "consent statement" described in paragraph 11 of subsection E of this section; and

3. The qualified physician signs the "qualified physician declaration" described in paragraph 12 of subsection E of this section.

E. The consent form shall include, but is not limited to, the following:

1. The probable gestational age of the unborn child as determined by both patient history and by ultrasound results used to confirm gestational age;

2. A detailed description of the steps to complete the chemical abortion;

3. A detailed list of the risks related to the specific abortion-inducing drug or drugs to be used including, but not limited to, hemorrhaging, failure to remove all tissue of the unborn child which may require an additional procedure, sepsis, sterility and possible continuation of pregnancy;

4. Information about Rh incompatibility including that if she has an Rh-negative blood type, she should receive an injection of Rh immunoglobulin at the time of the abortion to prevent Rh incompatibility in future pregnancies;

5. That the risks of complications from a chemical abortion including incomplete abortion, increase with advancing gestational age;

6. That it may be possible to reverse the effects of the chemical abortion should she change her mind, but that time is of the essence;

7. That she may see the remains of her unborn child in the process of completing the abortion;

8. That initial studies suggest that children born after reversing the effects of Mifeprex/mifepristone have no greater risk of birth defects than the general population;

9. That initial studies suggest there is no increased risk of maternal mortality after reversing the effects of Mifeprex/mifepristone;

10. That information on and assistance with reversing the effects of abortion-inducing drugs are available in the state-prepared materials;

11. An "acknowledgment of risks and consent statement" which shall be signed by the patient. The statement shall include, but is not limited to, the following declarations, which shall be individually initialed by the patient:

a. that the patient understands that the abortion-inducing drug regimen or procedure is intended to end her pregnancy and will result in the death of her unborn child,

b. that the patient is not being forced to have an abortion, that she has the choice not to have the abortion and that she may withdraw her consent to the abortion-inducing drug regimen even after she has begun the abortion-inducing drug regimen,

c. that the patient understands that the chemical abortion regimen or procedure to be used has specific risks and may result in specific complications,

d. that the patient has been given the opportunity to ask questions about her pregnancy, the development of her unborn child, alternatives to abortion, the abortion-inducing drug or drugs to be used and the risks and complications inherent to the abortion-inducing drug or drugs to be used,

e. that she was specifically told that "Information on the potential ability of qualified medical professionals to reverse the effects of an abortion obtained through the use of abortion-inducing drugs is available at www.abortionpillreversal.com, or you can contact (877) 558-0333 for assistance in locating a medical professional that can aide in the reversal of an abortion.",

f. that she has been provided access to state-prepared, printed materials on informed consent for abortion and the state-prepared and maintained website on informed consent for abortion,

g. if applicable, that she has been given the name and phone number of the associated physician who has agreed to provide medical care and treatment in the event of complications associated with the abortion-inducing drug regimen or procedure,

h. that the qualified physician will schedule an in-person follow-up visit for the patient at approximately seven (7) to fourteen (14) days after providing the abortion-inducing drug or drugs to confirm that the pregnancy is completely terminated and to assess the degree of bleeding and other complications, and

i. that the patient has received or been given sufficient information to give her informed consent to the abortion-inducing drug regimen or procedure, and

j. that the patient has a private right of action to sue the qualified physician under the laws of this state if she feels that she has been coerced or misled prior to obtaining an abortion, and how to access state resources regarding her legal right to obtain relief; and

12. A "qualified physician declaration", which shall be signed by the qualified physician, stating that the qualified physician has explained the abortion-inducing drug or drugs to be used, has provided all of the information required in subsection E of this section, and has answered all of the woman's questions.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-756.7 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The State Board of Medical Licensure and Supervision shall cause to be published in the state-prepared, printed materials on informed consent for abortion and the state-prepared and maintained website on informed consent for abortion the following statement:

"Information on the potential ability of qualified medical professionals to reverse the effects of an abortion obtained through the use of abortion-inducing drugs is available at www.abortionpillreversal.com, or you can contact (877) 558-0333 for assistance in locating a medical professional that can aid in the reversal of an abortion."

B. On an annual basis, the State Board of Medical Licensure and Supervision shall review and update, if necessary, the statement required in subsection A of this Section.

C. As part of the informed consent counseling required in Section 5 of this act, the qualified physician shall inform the pregnant woman about abortion pill reversal and provide her with the state-prepared materials and website link as proscribed by Section 6 of this act.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-756.8 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. For the purpose of promoting maternal health and adding to the sum of medical and public health knowledge through the compilation of relevant data, a report of each drug-induced abortion performed shall be made to the State Department of Health on forms prescribed by it. The reports shall be completed by the hospital or other licensed facility in which the abortion-inducing drug was given, sold, dispensed, administered or otherwise provided or prescribed; signed by the qualified physician who gave, sold, dispensed, administered or otherwise provided or prescribed the abortion-inducing drug; and transmitted to the Department within fifteen (15) days after each reporting month.

B. Each report shall include, at minimum, the following information:

1. Identification of the qualified physician who provided the abortion-inducing drug;

2. Whether the chemical abortion was completed at the hospital or licensed facility in which the abortion-inducing drug was provided or at an alternative location;

3. The referring physician, agency or service, if any;

4. The pregnant woman's age and race;

5. The number of previous pregnancies, number of live births and number of previous abortions of the pregnant woman;

6. The probable gestational age of the unborn child as determined by both patient history and by ultrasound results used to confirm the gestational age. The report shall include the date of the ultrasound and gestational age determined on that date;

7. The abortion-inducing drug or drugs used, the date each was provided to the pregnant woman and the reason for the abortion, if known;

8. Preexisting medical conditions of the pregnant woman which would complicate her pregnancy, if any;

9. Whether the woman returned for a follow-up examination to determine completion of the abortion procedure and to assess bleeding and the date and results of any such follow-up examination, and what reasonable efforts were made by the qualified physician to encourage that she return for a follow-up examination if she did not;

10. Whether the woman suffered any complications, and what specific complications arose and any follow-up treatment needed; and

11. The amount billed to cover the treatment for specific complications including whether the treatment was billed to Medicaid, private insurance, private pay or other method. This shall include charges for any physician, hospital, emergency room, prescription or other drugs, laboratory tests and any other costs for treatment rendered.

C. Reports required under this subsection shall not contain:

1. The name of the pregnant woman;

2. Common identifiers such as her social security number or driver license number; or

3. Other information or identifiers that would make it possible to identify, in any manner or under any circumstances, a woman who has obtained or seeks to obtain a chemical abortion.

D. If a qualified physician provides an abortion-inducing drug to a pregnant woman for the purpose of inducing an abortion as authorized in Sections 2 and 3 of this act, and if the qualified physician knows that the woman who uses the abortion-inducing drug for the purpose of inducing an abortion experiences, during or after the use of the abortion-inducing drug, an adverse event, the qualified physician shall provide a written report of the adverse event within three (3) days of the event to the Food and Drug Administration via the Medwatch Reporting System, and to the Department and to the State Board of Medical Licensure and Supervision.

E. Any physician, qualified physician, associated physician or other healthcare provider who treats a woman, either contemporaneously to or at any time after the procedure, for an adverse event or complication related to a chemical abortion shall make a report of the adverse event to the Department on forms prescribed by it. The reports shall be completed by the hospital or other facility in which the adverse event treatment was provided; signed by the physician, qualified physician or other healthcare provider who treated the adverse event; and transmitted to the Department within (15) days after each reporting month.

F. The Department shall prepare a comprehensive annual statistical report for the Legislature based upon the data gathered from reports under this section. The aggregated data shall also be made available to the public by the Department in a downloadable format.

G. The Department shall summarize aggregate data from the reports required under this act and submit the data to the Centers for Disease Control and Prevention.

H. Reports filed pursuant to this section shall be public records and shall be available to the public in accordance with the confidentiality and public records reporting laws of this state. Copies of all reports filed under this subsection shall be available to the State Board of Medical Licensure and Supervision, State Board of Pharmacy, state law enforcement offices and child protective services for use in the performance of their official duties.

I. Absent a valid court order or judicial subpoena, neither the Department, any other state department, agency or office nor any employees thereof shall compare data concerning abortions or abortion complications maintained in an electronic or other information system file with data in any other electronic or other information system with the intention of identifying, in any manner or under any circumstances, a woman obtaining or seeking to obtain a drug-induced abortion.

J. Statistical information that may reveal the identity of a woman obtaining or seeking to obtain a drug-induced abortion shall not be publicly disclosed by the Department, any other state department, agency, office or any employee or contractor thereof.

K. Copies of all reports filed under this section shall be available to the Department and the State Board of Medical Licensure and Supervision for use in the performance of its official duties.

L. The Department shall communicate the reporting requirements in this section to all medical professional organizations, licensed physicians, hospitals, emergency rooms, abortion facilities, clinics, ambulatory surgical facilities and other healthcare facilities operating in this state.

M. Any physician including emergency medical personnel, who treats a woman for complications or adverse event arising from an abortion, shall file a written report as required by this section of this act with the Department.

N. A physician filing a written report with the Department after treating a woman for complications or otherwise in an emergency capacity shall make reasonable efforts to include all of the required information that may be obtained without violating the privacy of the woman.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-756.9 of Title 63, unless there is created a duplication in numbering, reads as follows:

The State Department of Health shall create and distribute the forms required by this act within sixty (60) days after the effective date of this act. No provision of this act requiring the

reporting of information on forms published by the Department shall be applicable until ten (10) days after the requisite forms are first created and distributed or until the effective date of this act, whichever is later.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-756.10 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. A person who intentionally, knowingly or recklessly violates any provision of this act is guilty of a misdemeanor.

B. A person who intentionally, knowingly or recklessly violates any provision of this act by fraudulent use of an abortion-inducing drug, with or without the knowledge of the pregnant woman, is guilty of a felony.

C. No criminal penalty may be assessed against the pregnant woman upon whom the drug-induced abortion is attempted, induced or performed.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-756.11 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. In addition to whatever remedies are available under the common or statutory law of this state, failure to comply with the requirements of this act shall:

1. Provide a basis for a civil malpractice action for actual and punitive damages;

2. Provide a basis for a professional disciplinary action;

3. Provide a basis for recovery for the woman's survivors for the wrongful death of the woman; and

4. Provide a basis for a cause of action for injunctive relief against a person who has provided an abortion-inducing drug in violation of this act. Such an action may be maintained by:

a. a woman to whom such an abortion-inducing drug was provided,

b. a person who is the spouse, parent or guardian of, or a current or former licensed health care provider of, a woman to whom an abortion-producing drug was provided, or

c. a prosecuting attorney with appropriate jurisdiction.

The injunction shall prevent the defendant from providing further abortion-inducing drugs in violation of this act.

B. No civil liability may be assessed against the pregnant woman upon whom the drug-induced abortion is attempted, induced or performed.

C. When requested, the court shall allow a woman to proceed using solely her initials or a pseudonym and may close any proceedings in the case and enter other protective orders to preserve the privacy of the woman upon whom the drug-induced abortion was attempted, induced or performed.

D. If judgment is rendered in favor of the plaintiff, the court shall also render judgment for reasonable attorney fees in favor of the plaintiff against the defendant.

E. If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court may render judgment for reasonable attorney fees in favor of the defendant against the plaintiff.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-756.12 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. Nothing in this act shall be construed as creating or recognizing a right to abortion.

B. It is not the intention of this act to make lawful an abortion that is otherwise unlawful.

C. Nothing in this act repeals, replaces or otherwise invalidates existing federal or state laws, regulations or policies.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-756.13 of Title 63, unless there is created a duplication in numbering, reads as follows:

The Legislature, by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this act is challenged.

SECTION 14. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-756.14 of Title 63, unless there is created a duplication in numbering, reads as follows:

If any one or more provisions, sections, subsections, sentences, clauses, phrases or words of this act or the application thereof to any person or circumstance is found to be unconstitutional, the same is hereby declared to be severable and the balance of this act shall remain effective notwithstanding such unconstitutionality. The Legislature hereby declares that it would have passed this act, and each provision, section, subsection, sentence, clause, phrase or word thereof, irrespective of the fact that any one or more provisions, sections, subsections, sentences, clauses, phrases or words be declared unconstitutional.

SECTION 15. This act shall become effective November 1, 2021.

Passed the Senate the 19th day of May, 2021.

_____
Presiding Officer of the Senate

Passed the House of Representatives the 25th day of May, 2021.

_____
Presiding Officer of the House
of Representatives

OFFICE OF THE GOVERNOR

Received by the Office of the Governor this _____

day of _____, 20_____, at _____ o'clock _____ M.

By: _____

Approved by the Governor of the State of Oklahoma this _____

day of _____, 20_____, at _____ o'clock _____ M.

_____
Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Office of the Secretary of State this _____

day of _____, 20 _____, at _____ o'clock _____ M.

By: _____

# An Act

ENROLLED SENATE
BILL NO. 779

By: Daniels, Bullard, Stephens, David, Taylor, Jett and Bergstrom of the Senate

and

Lepak, Dills, Gann, Smith, Patzkowsky and Roberts (Sean) of the House

An Act relating to abortion; creating the Oklahoma Abortion-Inducing Drug Certification Program Act; defining terms; specifying applicability of act; directing creation of certification program; authorizing certain fees and contracts; limiting provision of abortion-inducing drugs to certain practitioners and procedures; directing promulgation of certain rules; directing establishment of certain requirements for manufacturers, distributors and physicians; providing certification systems and requirements for manufacturers, distributors and physicians; requiring physician to maintain hospital admitting privileges or enter into certain written agreement; stating conditions of agreement; requiring adoption of certain reporting system; stating criteria of reporting system; requiring certain reporting of physicians; providing for reporting of adverse events; providing criminal penalties; providing for certain civil remedies, disciplinary sanctions and injunctive relief; specifying certain judicial procedures; directing development of certain enforcement scheme; specifying criteria of enforcement scheme; providing for certain restitution; directing creation of certain public portals; requiring portals to list certain names and allow for certain complaints; providing for disposition of complaints; providing for confidentiality of complaints; providing certain

construction and intent; authorizing certain intervention; providing severability; amending 59 O.S. 2011, Section 353.7, as last amended by Section 4, Chapter 106, O.S.L. 2018 (59 O.S. Supp. 2020, Section 353.7), which relates to powers and duties of the State Board of Pharmacy; broadening allowed uses of fees; amending 59 O.S. 2011, Section 643, which relates to the State Board of Osteopathic Examiners Revolving Fund; amending 59 O.S. 2011, Section 644, as amended by Section 266, Chapter 304, O.S.L. 2012 (59 O.S. Supp. 2020, Section 644), which relates to the State Board of Osteopathic Examiners Revolving Fund; broadening sources and allowed uses of monies; providing for codification; and providing an effective date.

SUBJECT: Oklahoma Abortion-Inducing Drug Certification Program Act

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-757.1 of Title 63, unless there is created a duplication in numbering, reads as follows:

Sections 1 through 16 of this act shall be known and may be cited as the "Oklahoma Abortion-Inducing Drug Certification Program Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-757.2 of Title 63, unless there is created a duplication in numbering, reads as follows:

As used in this act:

1. "Abortion" means the act of using or prescribing any instrument, medicine, drug or any other substance, device or means with the intent to terminate the pregnancy of a woman known to be pregnant, with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child.

Such use, prescription or means is not an abortion if done with the intent to:

a. save the life or preserve the health of the unborn child,

b. remove a dead unborn child caused by spontaneous abortion, accidental trauma or a criminal assault on the pregnant woman or her unborn child,

c. remove an ectopic pregnancy, or

d. treat a maternal disease or illness for which the prescribed drug is indicated;

2. "Abortion-inducing drug" means a medicine, drug or any other substance prescribed or dispensed with the intent of terminating the pregnancy of a woman known to be pregnant, with knowledge that the termination will with reasonable likelihood cause the death of the unborn child. This includes the off-label use of drugs known to have abortion-inducing properties, which are prescribed specifically with the intent of causing an abortion, such as mifepristone (Mifeprex), misoprostol (Cytotec) and methotrexate. This definition does not apply to drugs that may be known to cause an abortion, but which are prescribed for other medical indications, such as chemotherapeutic agents and diagnostic drugs. The use of such drugs to induce abortion is also known as "medical", "medication", "RU-486", "chemical", "Mifeprex regimen" or "drug-induced" abortion;

3. "Adverse event", according to the Food and Drug Administration, means any untoward medical occurrence associated with the use of a drug in humans, whether or not considered drug-related. It does not include an adverse event or suspected adverse reaction that, had it occurred in a more severe form, might have caused death;

4. "Associated physician" means a person fully licensed and in good standing to practice medicine in the state including medical doctors and doctors of osteopathy, who has entered into an associated physician agreement;

5. "Complication" means any adverse physical or psychological condition arising from the performance of an abortion which includes, but is not limited to, uterine perforation, cervical perforation, infection, heavy or uncontrolled bleeding, hemorrhage, blood clots resulting in pulmonary embolism or deep vein thrombosis, failure to actually terminate the pregnancy, incomplete abortion (retained tissue), pelvic inflammatory disease, endometritis, missed ectopic pregnancy, cardiac arrest, respiratory arrest, renal failure, metabolic disorder, shock, embolism, coma, placenta previa in subsequent pregnancies, preterm delivery in subsequent pregnancies, free fluid in the abdomen, hemolytic reaction due to the administration of ABO-incompatible blood or blood products, adverse reactions to anesthesia and other drugs, subsequent development of breast cancer, psychological complications such as depression, suicidal ideation, anxiety, sleeping disorders, death and any other adverse event as defined by the Food and Drug Administration criteria provided in the Medwatch Reporting System;

6. "Gestational age" means the time that has elapsed since the first day of the woman's last menstrual period, also known as "last menstrual period" or "LMP";

7. "Hospital" means an institution providing medical and surgical treatment and nursing care for sick or injured people, or institutions defined under Section 1-701 of Title 63 of the Oklahoma Statutes;

8. "Manufacturers and distributors" means individuals or entities that create, produce, supply, transport or sell drugs, which include:

a. any substances recognized by an official pharmacopoeia or formulary,

b. any substances intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease,

c. any substances other than food intended to affect the structure or any function of the body, or

d. any substances intended for use as a component of a medicine but not a device or a component, part or accessory of a device;

9. "Obstetrician/gynecologist", also known as OB/GYN, means a licensed physician who specializes in the care of women during pregnancy and childbirth and in the diagnosis and treatment of diseases of the female reproductive organs and specializes in other women's health issues such as menopause, hormone problems, contraception or birth control, and infertility;

10. "Physician" means any person fully licensed by and in good standing with the State Board of Medical Licensure and Supervision or the State Board of Osteopathic Examiners to practice medicine in this state. The term includes medical doctors and doctors of osteopathy;

11. "Pregnant" or "pregnancy" means that female reproductive condition of having an unborn child in the mother's uterus;

12. "Provide" or "provision" means, when used regarding abortion-inducing drugs, any act of giving, selling, dispensing, administering, transferring possession to or otherwise providing or prescribing an abortion-inducing drug; and

13. "Unborn child" means an individual organism of the species *Homo sapiens*, beginning at fertilization, until the point of being born-alive as defined in Title 1 U.S.C., Section 8(b).

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-757.3 of Title 63, unless there is created a duplication in numbering, reads as follows:

This act applies to any physician, health care provider or other person who is providing abortion-inducing drugs for use within this state, or any manufacturer or distributor providing abortion-inducing drugs within this state.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-757.4 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The State Board of Pharmacy, the State Board of Medical Licensure and Supervision and the State Board of Osteopathic Examiners shall create a certification program for abortion-inducing drugs. The program shall be known as the Oklahoma Abortion-Inducing Drug Certification Program.

B. The State Board of Medical Licensure and Supervision, the State Board of Osteopathic Examiners and the State Board of Pharmacy may assess reasonable fees on their respective licensees and enter into contracts with persons or entities to implement the Oklahoma Abortion-Inducing Drug Certification Program.

C. Abortion-inducing drugs shall not be provided directly to the patient through the mail, telemedicine or otherwise outside of the parameters of the Oklahoma Abortion-Inducing Drug Certification Program.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-757.5 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The State Board of Pharmacy shall promulgate rules to create a certification program to oversee and regulate the manufacture and distribution of abortion-inducing drugs by manufacturers and distributors licensed by the State Board of Pharmacy.

B. The State Board of Pharmacy shall establish the following requirements for manufacturers and distributors of abortion-inducing drugs, at a minimum:

1. Require completion of the certification process for manufacturers and distributors as described in Section 6 of this act;

2. Require that abortion-inducing drugs be transported and provided in this state only by manufacturers or distributors certified to do so under this program;

3. Notify manufacturers and distributors of physicians certified under the Oklahoma Abortion-Inducing Drug Certification Program;

4. Prohibit shipment of abortion-inducing drugs to physicians who become de-certified from the Oklahoma Abortion-Inducing Drug Certification Program;

5. Audit newly certified manufacturers and distributors within ninety (90) calendar days after the manufacturer or distributor is authorized, and annually thereafter, to ensure that all processes and procedures are in place and functioning to support the requirements of the Oklahoma Abortion-Inducing Drug Certification Program;

6. If a manufacturer or distributor is found to be noncompliant, immediately suspend manufacturer's or distributor's certification until the manufacturer or distributor demonstrates full compliance; and

7. Enforce compliance according to Section 12 of this act.

C. The State Board of Medical Licensure and Supervision and the State Board of Osteopathic Examiners shall promulgate rules to create a certification program to oversee and regulate the provision of abortion-inducing drugs by physicians licensed by the respective state licensing board. The drugs shall only be provided to patients by fully licensed physicians certified to do so under this program by their respective state licensing boards.

D. The State Board of Medical Licensure and Supervision and the State Board of Osteopathic Examiners shall establish the following requirements for physicians providing abortion-inducing drugs, at a minimum:

1. Require completion of the certification process for physicians as described in Section 7 of this act;

2. Audit newly certified physicians within ninety (90) calendar days after the physician is authorized, and annually thereafter, to ensure that all required processes and procedures are in place and functioning to support the requirements of the Oklahoma Abortion-Inducing Drug Certification Program;

3. If a physician is found to be noncompliant, immediately suspend the physician's certification until such time that the physician demonstrates full compliance;

4. Develop a reporting system as specified in Section 9 of this act; and

5. Enforce compliance according to Section 12 of this act.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-757.6 of Title 63, unless there is created a duplication in numbering, reads as follows:

The State Board of Pharmacy shall adopt a certification system for any manufacturer or distributor intending to provide abortion-inducing drugs in the state. To be eligible to be certified under this section, manufacturers and distributors shall:

1. Be licensed by the Board;

2. Only distribute to physicians certified under this act;

3. Record each serial number from pharmaceutical packages distributed to each certified physician;

4. Abide by all applicable standards of the Utilization Review Accreditation Commission (URAC) or National Association of Boards of Pharmacy (NABP);

5. For online sales or orders, hold a current ".pharmacy" or ".pharma" domain and abide by all the standards required by the NABP to maintain the domain;

6. Follow all other applicable state or federal laws related to the distribution or delivery of legend drugs including abortion-inducing drugs; and

7. Follow all acceptable processes and procedures to maintain a distribution or delivery system that is secure, confidential and follows all processes and procedures including those for storage, handling, shipping, tracking package serial numbers, proof of delivery and controlled returns of abortion-inducing drugs.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-757.7 of Title 63, unless there is created a duplication in numbering, reads as follows:

The State Board of Medical Licensure and Supervision and the State Board of Osteopathic Examiners shall adopt a certification system for any physician intending to provide abortion-inducing drugs to patients in the state. Individuals or physicians providing abortion-inducing drugs in other states are not automatically certified in this state, and shall be fully certified under this law prior to providing any abortion-inducing drugs to any pregnant women in this state. To be eligible to be certified under this section physicians shall:

1. Be fully licensed by and in good standing with either the State Board of Medical Licensure and Supervision or the State Board of Osteopathic Examiners to practice medicine in the state;

2. Examine any patient in person prior to providing abortion-inducing drugs;

3. Sign an annual "Dispensing Agreement Form", to be developed and provided by the physician's state licensing board, before providing abortion-inducing drugs;

4. Inform the patient of gestational age-specific risks of using abortion-inducing drugs;

5. Assess for signs of domestic abuse, reproductive control, human trafficking and other signals of coerced abortion, per current state guidelines;

6. Adequately inform the patient of gestational age-specific age risks of using abortion-inducing drugs;

7. Inform the patient that she may see the remains of her unborn child in the process of completing the abortion;

8. Inform the patient that studies show that babies born following the abortion reversal process have a rate of birth defects no higher than the general population;

9. Inform the patient that studies show that following this reversal process or otherwise treating a woman with progesterone during pregnancy does not lead to increased mortality rates;

10. Refrain from knowingly supplying abortion-inducing drugs to patients who present with any of the following:

a. absence of a pregnancy,

b. being post-seventy days gestation or post-ten weeks of pregnancy, and

c. having risk factors associated with abortion-inducing drugs including, but not limited to:

(1) ectopic pregnancies,

(2) problems with the adrenal glands near the kidneys,

(3) being treated with long-term corticosteroid therapy,

(4) allergic reactions to abortion-inducing drugs, mifepristone, misoprostol or similar drugs,

(5) bleeding problems or is taking anticoagulant drug products,

(6) has inherited porphyria,

(7) has an intrauterine device in place, or

(8) being Rh Negative, requiring administration of Rhogam before providing abortion-inducing drugs;

11. Provide or refer for emergency surgical intervention in cases of incomplete abortion, severe bleeding or other medical complications, through maintaining hospital admitting privileges or entering into a written agreement with an associated physician as specified in Section 8 of this act;

12. Assure patient access to medical facilities equipped to provide blood transfusions and resuscitation or other necessary treatments, if necessary;

13. Sign, and ensure that the patient signs, all legally required informed consent material, providing patient with a copy showing both signatures, and placing the original in the patient's medical record;

14. Record the serial number from each package of each abortion-inducing drug given to the patient in her medical record;

15. Submit a written protocol of how efforts will be made to schedule with the patient the medically indicated follow-up appointment within fourteen (14) days to assure a completed abortion;

16. Report to the State Board of Pharmacy, the physician's state licensing board and the Food and Drug Administration, any death associated with abortion-inducing drugs with the following guidelines:

a. the patient shall be noted by a non-identifiable reference and the serial number from each package of abortion-inducing drug given, whether or not considered drug-related,

b. this shall be done as soon as possible but no later than fifteen (15) calendar days from the initial receipt of the information by the physician, and

c. this requirement does not affect the physician's other reporting and follow-up requirements under the Oklahoma Abortion-Inducing Drug Certification Program or any additional requirements by another department that oversees the abortion industry in this state;

17. Submit a written protocol of how complications will be handled by the certified physician and submit a copy of a signed contract with an associated physician credentialed to handle certain complications as outlined in Section 8 of this act;

18. Abide by all applicable state and federal laws regarding medical records retention, confidentiality and privacy; and

19. Agree to follow and document compliance with all other legally required conditions for performing abortion in the state where the patient presents for her appointment including, but not limited to, waiting periods, informed consent requirements, statistical reporting, parental consent or notification and required inspections.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-757.8 of Title 63, unless there is created a duplication in numbering, reads as follows:

The State Board of Medical Licensure and Supervision and the State Board of Osteopathic Examiners shall also require the following of certified physicians:

1. Maintaining hospital admitting privileges at one or more hospitals in the county or contiguous county where the abortion-inducing drug was provided, and informing the patient of any hospital where the physician holds admitting privileges; or

2. Alternatively, the physician may enter into a written agreement with an associated physician in the county or contiguous county where the abortion-inducing drug was provided. The written agreement shall meet these conditions:

a. a physician who provides an abortion-inducing drug shall notify the patient of the location of the hospital at which the associated physician has admitting privileges,

b. the physician shall keep, at the location of his or her practice, a copy of the written agreement,

c. the physician shall submit a copy of the written agreement to their state licensing board and the State Department of Health as part of any required clinic licensure,

d. the State Department of Health shall verify the validity of the document, and shall remove any personal identifying information of the patient from the document before releasing the document in accordance with the following:

(1) the State Department of Health shall annually submit a copy of the written agreement described in this paragraph to each hospital located in the county or a county that is contiguous to the county where the abortion was performed, and

(2) the State Department of Health shall confirm to a member of the public, upon request, that the written agreement required to be submitted under this section for an abortion clinic has been received by the Department,

e. the agreement shall be renewed annually, or more often as required by the physician's state licensing board,

f. the agreement shall include a requirement that the physician provide to the patient and require the patient to sign all legally required informed consent material, and

g. the agreement shall require the adherence to all reporting requirements from the State Department of Health and the physician's licensing board.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-757.9 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The State Board of Medical Licensure and Supervision and the State Board of Osteopathic Examiners shall adopt an electronically based reporting system for certified physicians to report annually the following:

1. The number of patients served;

2. Age of patients served;

3. Race of patients served;

4. County and state of residence of patients served;

5. If the patient resides outside the United States, city and country of residence;

6. County and state of service;

7. A list of staff attending patients including licensing numbers and evidence of other qualifications;

8. Each medication used or provided per patient, by date;

9. Any known complications or adverse events, and how they were addressed, by date; and

10. Unresolved cases.

B. This reporting system shall also be used by emergency department physicians and private physicians who treat post-abortion complications.

C. Physicians shall protect from disclosure any personally identifiable information of the patient in accordance with applicable federal and state law.

D. A certified physician shall also report to their licensing board, the State Board of Pharmacy and the Medwatch Reporting System of the Food and Drug Administration (FDA), any complication or adverse event as defined according to the FDA criteria given in the Medwatch Reporting System.

E. The State Board of Medical Licensure and Supervision and the State Board of Osteopathic Examiners shall develop a system of reporting adverse events from the use of abortion-inducing drugs for this state. The system shall require reporting of complications and adverse events including, but not limited to:

1. Death;

2. Blood loss including hemorrhage;

3. Infection including sepsis;

4. Blood transfusions;

5. Administer drug for an ectopic pregnancy; and

6. Other adverse effects requiring hospitalization or additional medical care.

F. The State Board of Medical Licensure and Supervision and the State Board of Osteopathic Examiners shall require the following providers and entities to report complications and adverse events in writing:

1. Physicians certified to provide abortion-inducing drugs;

2. Emergency room physicians;

3. Any doctor licensed in this state including an obstetrician/gynecologist who treats women with adverse events;

4. Provision of certification requires that the physician shall also report adverse events and any patient deaths to the FDA; and

5. Other individuals or entities as determined by the State Board of Medical Licensure and Supervision or the State Board of Osteopathic Examiners.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-757.10 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. Individuals or entities not certified under the Oklahoma Abortion-Inducing Drug Certification Program that provide drugs for the purpose of inducing abortion are in violation of this act.

B. Individuals or entities that provide abortion-inducing drugs to any person or entity that is not certified, or otherwise authorized, to provide abortion-inducing drugs under the Oklahoma

Abortion-Inducing Drug Certification Program are in violation of this act.

C. A person who intentionally, knowingly or recklessly violates any provision of this act is guilty of a misdemeanor.

D. A person who intentionally, knowingly or recklessly violates any provision of this act by fraudulent use of an abortion-inducing drug, with or without the knowledge of the pregnant woman, is guilty of a felony.

E. No civil or criminal penalty may be assessed against the pregnant woman upon whom the drug-induced abortion is attempted, induced or performed.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-757.11 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. In addition to whatever remedies are available under the common or statutory law of this state, failure to comply with the requirements of this act shall:

1. Provide a basis for a civil malpractice action for actual and punitive damages;

2. Provide a basis for a professional disciplinary action; and

3. Provide a basis for recovery for the woman's survivors for the wrongful death of the woman.

B. When requested, the court shall allow a woman to proceed using solely her initials or a pseudonym and may close any proceedings in the case and enter other protective orders to preserve the privacy of the woman upon whom the drug-induced abortion was attempted, induced or performed.

C. If judgment is rendered in favor of the plaintiff, the court shall also render judgment for reasonable attorney fees in favor of the plaintiff against the defendant.

D. If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court may render judgment for reasonable attorney fees in favor of the defendant against the plaintiff.

E. A cause of action for injunctive relief against a person who has provided an abortion-inducing drug in violation of this act may be maintained by:

1. A woman to whom such an abortion-inducing drug was provided;

2. A person who is the spouse, parent or guardian of, or a current or former licensed health care provider of, a woman to whom such an abortion-inducing drug was provided; or

3. A prosecuting attorney with appropriate jurisdiction.

The injunction shall prevent the defendant from providing further abortion-inducing drugs in violation of this act.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-757.12 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The State Board of Pharmacy, the State Board of Medical Licensure and Supervision and the State Board of Osteopathic Examiners shall develop an enforcement scheme for their licensees to enforce this act, which includes:

1. When an individual or entity provides abortion-inducing drugs without first seeking certification under this act, the appropriate licensing board shall:

a. immediately report the illegal act to local law enforcement, or other applicable state and local agencies for investigation or other appropriate action, where appropriate, and

b. impose a fine of no less than Five Million Dollars ($5,000,000.00) for manufacturers or distributors and Two Hundred Fifty Thousand Dollars ($250,000.00) for physicians;

2. When a certified manufacturer, distributor or physician is determined to be in noncompliance, suspend certification until compliance is proven to the satisfaction of their licensing board;

3. Where a current or previously certified manufacturer or distributer is found to have intentionally or knowingly violated this act, or refuses to bring operations into compliance within ninety (90) calendar days, remove certification and prohibit continued provision of abortion-inducing drugs by the manufacturer or distributor until compliance is demonstrated to the satisfaction of their licensing board;

4. When a certified manufacturer, distributor or physician is in noncompliance, suspend all annual recertification until compliance is demonstrated to the satisfaction of their licensing board; and

5. Where a current or previously certified manufacturer, distributor or physician is found to have intentionally or knowingly violated this act, or refuses to bring operations into compliance:

a. immediately suspend the manufacturer's, distributor's or physician's certification until full compliance is demonstrated,

b. for certified manufacturers or distributors, impose fines of not less than One Million Dollars ($1,000,000.00) per offense, by the State Board of Pharmacy,

c. for certified physicians, impose fines of not less than One Hundred Thousand Dollars ($100,000.00) per offense, by the physician's licensing board,

d. permanently revoke the certification of the offender if offender fails to demonstrate compliance with their licensing board within ninety (90) calendar days,

e. impose remedial actions, which may include additional education, additional reporting or other actions as required by the relevant licensing board,

f. in the case of a manufacturer or distributor, recommend sanctioning to the appropriate disciplinary committee of the State Board of Pharmacy,

g. in the case of a physician, report the violation to the appropriate physician licensing board,

h. publicly report any disciplinary actions, consistent with the practices of the relevant licensing board,

i. permanently revoke the certification of the offender,

j. in the case of a licensed manufacturer or distributor, recommend permanent revocation of licensure,

k. in the case of a physician, recommend appropriate sanctioning to the appropriate physician licensing board, and

l. publicly report any disciplinary actions consistent with the practices of the relevant licensing board.

B. Individuals have a Private Right of Action to seek restitution in any court of law with appropriate jurisdiction for any and all damages suffered due to a violation of this act.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-757.13 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The State Board of Pharmacy shall develop on its website a complaint portal for patients, pharmacy, nursing and medical professionals and the public to submit information about potential violations by nonphysicians at no charge to the parties named in this subsection.

B. The State Board of Medical Licensure and Supervision and the State Board of Osteopathic Examiners shall develop on their respective websites a complaint portal for patients, pharmacy, nursing and medical professionals and the public to submit

information about potential violations by physicians at no charge to the parties named in this subsection.

C. The portal developed by the State Board of Pharmacy shall list the names of manufacturers and distributors that are certified under the program.

D. The portals developed by the State Board of Medical Licensure and Supervision and the State Board of Osteopathic Examiners shall list the names of the fully licensed physicians certified under the program.

E. The portal shall allow the party to make a complaint anonymously.

F. The State Board of Pharmacy and physician licensing boards shall review each complaint and determine a disposition including referral to another appropriate state agency, within thirty (30) days of receipt of a complaint.

G. Confidentiality of the originator of the complaint shall be protected at all times except for intra-state referrals for investigation or if any disciplinary action is brought by a licensing board pursuant to this act.

SECTION 14. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-757.14 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. Nothing in this act shall be construed as creating or recognizing a right to abortion.

B. It is not the intention of this act to make lawful an abortion that is otherwise unlawful.

C. Nothing in this act repeals, replaces or otherwise invalidates existing federal or state laws, regulations or policies.

SECTION 15. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-757.15 of Title 63, unless there is created a duplication in numbering, reads as follows:

The Legislature, by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this act is challenged.

SECTION 16. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-757.16 of Title 63, unless there is created a duplication in numbering, reads as follows:

If any one or more provisions, sections, subsections, sentences, clauses, phrases or words of this act or the application thereof to any person or circumstance is found to be unconstitutional, the same is hereby declared to be severable and the balance of this act shall remain effective notwithstanding such unconstitutionality. The Legislature hereby declares that it would have passed this act, and each provision, section, subsection, sentence, clause, phrase or word thereof, irrespective of the fact that any one or more provisions, sections, subsections, sentences, clauses, phrases or words be declared unconstitutional.

SECTION 17. AMENDATORY 59 O.S. 2011, Section 353.7, as last amended by Section 4, Chapter 106, O.S.L. 2018 (59 O.S. Supp. 2020, Section 353.7), is amended to read as follows:

Section 353.7. The State Board of Pharmacy shall have the power and duty to:

1. Regulate the practice of pharmacy;

2. Regulate the sale and distribution of drugs, medicines, chemicals and poisons;

3. Regulate the dispensing of drugs and medicines in all places where drugs and medicines are compounded and/or dispensed;

4. Examine and issue appropriate certificates of licensure as Doctor of Pharmacy to all applicants whom the Board deems qualified under the provisions of the Oklahoma Pharmacy Act;

5. Issue licenses to manufacturers, repackagers, outsourcing facilities, wholesale distributors, third-party logistics providers,

pharmacies, and other dispensers, medical gas suppliers, and medical gas distributors;

6. Issue sterile compounding and drug supplier permits for pharmacies at the fee set by the Board, with the expiration date of such permits to coincide with the pharmacy license annual expiration date;

7. Prescribe minimum standards with respect to floor space and other physical characteristics of pharmacies and hospital drug rooms as may be reasonably necessary for the maintenance of professional surroundings and for the protection of the safety and welfare of the public, and to refuse the issuance of new or renewal licenses for failure to comply with such standards. Minimum standards for hospital drug rooms shall be consistent with the State Department of Health, Hospital Standards, as defined in OAC 310:667;

8. Authorize its inspectors, compliance officers, and duly authorized representatives to enter and inspect any and all places, including premises, vehicles, equipment, contents and records, where drugs, medicines, chemicals, or poisons are stored, sold, vended, given away, compounded, dispensed, manufactured, repackaged or transported;

9. Employ the number of inspectors and pharmacist compliance officers necessary in the investigation of criminal activity or preparation of administrative actions at an annual salary to be fixed by the Board, and to authorize necessary expenses. Any inspector certified as a peace officer by the Council of Enforcement Education and Training shall have statewide jurisdiction to perform the duties authorized by this section. In addition, the inspectors shall be considered peace officers and shall have the same powers and authority as that granted to peace officers. In addition, such inspectors or pharmacist compliance officers shall have the authority to take and copy records and the duty to confiscate all drugs, medicines, chemicals or poisons found to be stored, sold, vended, given away, compounded, dispensed or manufactured contrary to the provisions of the Oklahoma Pharmacy Act;

10. Investigate complaints, subpoena witnesses and records, initiate prosecution, and hold hearings;

11. Administer oaths in all manners pertaining to the affairs of the Board and to take evidence and compel the attendance of witnesses on questions pertaining to the enforcement of the Oklahoma Pharmacy Act;

12. Reprimand, place on probation, suspend, revoke permanently and levy fines not to exceed Three Thousand Dollars ($3,000.00) for each count for which any person charged with violating the Oklahoma Pharmacy Act or Oklahoma Board of Pharmacy administrative rules has been convicted in Board hearings. The Board also may take other disciplinary action. The Board may impose as part of any disciplinary action the payment of costs expended by the Board for any legal fees and costs~~,~~ including, but not limited to, staff time, salary and travel expense, witness fees and attorney fees. The Board may also require additional continuing education~~,~~ including attendance at a live continuing education program, and may require participation in a rehabilitation program for the impaired. The Board may take such actions singly or in combination, as the nature of the violation requires;

13. Adopt and establish rules of professional conduct appropriate to the establishment and maintenance of a high standard of integrity and dignity in the profession of pharmacy. Such rules shall be subject to amendment or repeal by the Board as the need may arise;

14. Make and publish rules such as may be necessary for carrying out and enforcing the provisions of the Oklahoma Pharmacy Act, Oklahoma drug laws and rules, federal drug laws and regulations, and make such other rules as in its discretion may be necessary to protect the health, safety~~,~~ and welfare of the public;

15. Establish and collect appropriate fees for licenses, permits, inspections~~,~~ and services provided; and such fees shall be nonrefundable. Such fees shall be promulgated to implement the provisions of the Oklahoma Pharmacy Act and the Oklahoma Abortion-Inducing Drug Certification Program Act under the provisions of the Administrative Procedures Act;

16. Regulate:

a. personnel working in a pharmacy, such as interns and supportive personnel~~,~~ including technicians, and issue pharmacy technician permits and intern licenses,

b. interns, preceptors and training areas through which the training of applicants occurs for licensure as a pharmacist, and

c. such persons regarding all aspects relating to the handling of drugs, medicines, chemicals~~,~~ and poisons;

17. Acquire by purchase, lease, gift, solicitation of gift or by any other manner, and to maintain, use and operate or to contract for the maintenance, use and operation of or lease of any and all property of any kind, real, personal or mixed or any interest therein unless otherwise provided by the Oklahoma Pharmacy Act; provided, all contracts for real property shall be subject to the provisions of Section 63 of Title 74 of the Oklahoma Statutes;

18. Perform other such duties, exercise other such powers and employ such personnel as the provisions and enforcement of the Oklahoma Pharmacy Act may require; and

19. Approve pilot projects designed to utilize new or expanded technology or processes and provide patients with better pharmacy products or provide pharmacy services in a more safe and efficient manner. Such approvals may include provisions granting exemptions to any rule adopted by the Board.

SECTION 18. AMENDATORY 59 O.S. 2011, Section 643, is amended to read as follows:

Section 643. The funds received pursuant to the Oklahoma Osteopathic Medicine Act or the Oklahoma Abortion-Inducing Drug Certification Program Act shall be deposited to the credit of the State Board of Osteopathic Examiners Revolving Fund and may be expended by the State Board of Osteopathic Examiners and under its direction in assisting in the enforcement of the laws of this state prohibiting the unlawful practice of osteopathic medicine, assisting in the support of a peer assistance program, and for the dissemination of information to prevent the violation of such laws, and for the purchasing of supplies and such other expense as is

necessary to properly carry out the provisions of the Oklahoma Osteopathic Medicine Act or the Oklahoma Abortion-Inducing Drug Certification Program Act.

SECTION 19. AMENDATORY 59 O.S. 2011, Section 644, as amended by Section 266, Chapter 304, O.S.L. 2012 (59 O.S. Supp. 2020, Section 644), is amended to read as follows:

Section 644. There is hereby created in the State Treasury a revolving fund for the State Board of Osteopathic Examiners, to be designated the "State Board of Osteopathic Examiner's Revolving Fund". The fund shall be a continuing fund, not subject to fiscal year limitations, and shall consist of all monies received by the Board pursuant to the provisions of the Oklahoma Osteopathic Medicine Act or the Oklahoma Abortion-Inducing Drug Certification Program Act. All monies accruing to the credit of said fund are hereby appropriated and may be budgeted and expended by the Board for the purpose of enforcing the laws of this state which prohibit the unlawful practice of osteopathic medicine, for the dissemination of information to prevent the violation of such laws~~,~~ and for the purchase of supplies and such other expense as is necessary to properly implement the provisions of the Oklahoma Osteopathic Medicine Act or the Oklahoma Abortion-Inducing Drug Certification Program Act. Expenditures from said fund shall be made upon warrants issued by the State Treasurer against claims signed by an authorized employee or employees of the State Board of Osteopathic Examiners and filed as prescribed by law with the Director of the Office of Management and Enterprise Services for approval and payment.

SECTION 20. This act shall become effective November 1, 2021.

Passed the Senate the 19th day of May, 2021.

_____
Presiding Officer of the Senate

Passed the House of Representatives the 25th day of May, 2021.

_____
Presiding Officer of the House
of Representatives

OFFICE OF THE GOVERNOR

Received by the Office of the Governor this _____

day of _____, 20_____, at _____ o'clock _____ M.

By: _____

Approved by the Governor of the State of Oklahoma this _____

day of _____, 20_____, at _____ o'clock _____ M.

_____
Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Office of the Secretary of State this _____

day of _____, 20 _____, at _____ o'clock _____ M.

By: _____

**IN THE DISTRICT COURT OF OKLAHOMA COUNTY**
**STATE OF OKLAHOMA**

OKLAHOMA CALL FOR REPRODUCTIVE JUSTICE, on behalf of itself and its members; TULSA WOMEN'S REPRODUCTIVE CLINIC, LLC, on behalf of itself, its physicians, its staff, and its patients; ALAN BRAID, M.D., on behalf of himself and his patients; COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, INC., on behalf of itself, its physicians, its staff, and its patients; and PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, on behalf of itself, its physicians, its staff, and its patients,

Plaintiffs,

v.

JOHN O'CONNOR, in his official capacity as Attorney General for the State of Oklahoma; DAVID PRATER, in his official capacity as District Attorney for Oklahoma County; STEVE KUNZWEILER, in his official capacity as District Attorney for Tulsa County; LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; KATIE TEMPLETON, in her official capacity as President of the Oklahoma State Board of Osteopathic Examiners; LANCE FRYE, in his official capacity as the Commissioner of the Oklahoma State Board of Health; and JUSTIN WILSON, in his official capacity as the President of the Oklahoma State Board of Pharmacy; as well as their employees, agents, and successors,

Defendants.

CASE NO._____

**AFFIDAVIT OF PRIYA DESAI IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY INJUNCTION**

Priya Desai declares and states the following:

1. I am a Board Member of Oklahoma Call for Reproductive Justice ("OCRJ"), a Plaintiff in this case. OCRJ is a 501(c)(4) nonprofit founded in 2010 to advance reproductive justice and protect access to reproductive healthcare, including abortion, in Oklahoma. OCRJ is exclusively dedicated to this cause. I have been involved with OCRJ since its founding and served as a Co-Chair of OCRJ from August 2016 to August 2020.

2. Oklahoma has a long history of encroaching on reproductive freedom. In 2010, the Oklahoma Legislature enacted a number of bills restricting abortion. That slate of bills included an ultrasound requirement mandating that a physician perform an ultrasound at least one hour before a procedure, similar to a component of one of the bills challenged in this case. Activists came together at the state capitol to protest what was then an unprecedent attack on reproductive freedom. OCRJ emerged out of this protest.

3. We are an all-volunteer organization with an executive board and two Co-Chairs. OCRJ is funded primarily by donations, although we occasionally apply for grants.

4. OCRJ's membership includes Oklahomans of reproductive age who may need to terminate a pregnancy in Oklahoma in the future. These Oklahomans pay taxes to the State. Oklahomans of reproductive age include cis women but also transgender men, gender-nonbinary individuals, and gender-diverse individuals who may also become pregnant and seek abortion services.

5. Unfortunately, since 2010, the State has only become more emboldened in its assault on reproductive healthcare. I understand that the five bills challenged in this lawsuit impose a tremendous number of restrictions on abortion, and one law essentially bars access to abortion in Oklahoma entirely. OCRJ's mission requires that we combat these restrictions to

protect the reproductive freedoms of the Oklahomans across the state that we represent—people who need access to abortion care and support the ability of others to access abortion.

***Reproductive Justice in Oklahoma***

6. OCRJ's mission is to promote reproductive justice in Oklahoma through education, empowerment, and advocacy. Reproductive justice is a framework developed by Black women to reflect the many intersecting ways people of color face challenges in forming their families. Reproductive justice includes not just access to abortion, but also:

- the ability of Oklahomans to decide if and when they will have a baby and the conditions under which they will give birth;
- the ability to parent the children they already have with the necessary social supports in safe environments and healthy communities—supports including good schools and healthcare and other elements necessary for bright futures, regardless of immigration status, and without fear of violence from individuals or the government;
- and, if they decide they will not have a baby, their ability to prevent or end a pregnancy.

Black and Indigenous Oklahomans and other Oklahomans of color face heightened challenges across this spectrum of reproductive choices. These same communities have experienced oppression for generations, dating back to horrific race- and gender-based violence. And, today, these same communities disproportionately experience poverty and lack of access to healthcare, education, and other services.

***OCRJ's Work in Oklahoma and Its Mission***

7. OCRJ advances reproductive justice in many ways. We advocate for or against bills in the legislature—we lobby against bills like the laws challenged in this case, but we have also supported the few bills that help pregnant people, including the legislation that barred shackling of pregnant incarcerated patients during labor. Prior to the pandemic, we hosted lobby days, during which we organized supporters to lobby members of the legislature. We have also rapidly deployed volunteers when we think there is an emergency threat in the legislature. We hold events for our legislative champions. When we can, we speak to the media in order to educate Oklahomans about legislation and the potential impact of such legislation on Oklahomans' access to reproductive healthcare.

8. We also provide education in the community and communicate directly with Oklahomans. We speak about our issues at community events. People follow our social media accounts where we share information about our advocacy and mission. We send out "Action Alerts" to mobilize people for advocacy opportunities. We participate in conferences, including by presenting on panels. We also publish a zine, *How to Get an Abortion in Oklahoma*, which is updated regularly and provides information to Oklahomans who need to navigate the many overlapping laws restricting abortion in the State. Since many in Oklahoma do not have access to a computer or the internet, we do our best to print copies of our zine and place them in libraries, facilities for domestic violence survivors, and any other community partner that is willing to have them. We have found that this is one of our most essential services given that there is a lot of confusion caused by the legislature's continued attacks on abortion. We often find that some Oklahomans believe that abortion is currently illegal in the State. Further, quality sex education is extremely poor if not entirely absent in many parts of the State. It is key that we provide non-judgmental information about abortion and how to access it given these realities.

9. It is particularly important for us to disrupt the stigma attached to abortion, abortion providers, and patients. For example, we joined together with faith leaders for a campaign called Faith & Abortion, through which we challenged the idea that abortion is immoral or inconsistent with all faiths. We also held a campaign called Abortion is an Act of Love where we highlighted compassion for ourselves and our communities in making decisions around reproductive healthcare.

10. Our supporters are diverse in their party affiliation, economic background, and lived experience, but all believe that pregnant Oklahomans deserve the ability to make decisions about their healthcare in line with their own values and intentions.

***Impact of the Challenged Laws***

11. The Challenged Laws will frustrate our mission and prevent us from advancing reproductive justice for all Oklahomans. As an advocacy organization, we cannot imagine all of the ways that these laws will impact providers and patients should even one go into effect, but we understand that if the laws are not blocked, they will essentially bar abortion care in the state entirely. Each law alone would dramatically harm access to abortion.

12. We understand that H.B. 1102 bans abortion entirely by declaring that providing abortion—constitutionally-protected healthcare—is unprofessional conduct by physicians requiring, at a minimum, suspension of licensure for one year. If abortions were entirely unavailable, every patient in Oklahoma would have to forego abortion and carry an unwanted pregnancy to term or, if they are able, travel long distances out of state to get care.

13. We understand that H.B. 2441 bans abortion at approximately six weeks in pregnancy, and that generally only a minority of patients know they are pregnant and are able to

receive care prior to that point in pregnancy. This would bar a large percentage of patients from receiving care in Oklahoma.

14. We understand that H.B. 1904 will significantly reduce the number of abortion providers in the state by barring highly skilled and competent physicians, including family medicine doctors, from providing abortions because they are not board-certified OB/GYNs. A large reduction in the number of physicians providing care in the state would have dramatic effects on access given how few providers there are in the state.

15. We understand that S.B. 778 imposes a severely burdensome, medically unnecessary scheme solely on doctors providing medication abortion. This scheme's many requirements even include an ultrasound requirement just for medication abortion (which must be obtained at least 72 hours in advance)—a requirement even more draconian than a similar ultrasound requirement that the Oklahoma Supreme Court declared unconstitutional.[1] For patients who do not get an ultrasound elsewhere, they must make two trips to the clinic, which would maximize the delays and barriers they face.

16. We understand that S.B. 779 requires various agencies to impose an equally intricate system of requirements for manufacturers, distributors, and providers of medication abortion. As just one example of this law's many provisions, the bill includes a requirement that providers of medication abortion have admitting privileges or contract with a physician who does. This component is similar to the admitting privileges requirement deemed unconstitutional by both the Oklahoma Supreme Court and the United States Supreme Court.[2]

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[1] *Nova Health Sys. v. Pruitt*, 2012 OK 103, 292 P.3d 28.

[2] *Burns v. Cline*, 2016 OK 121, 387 P.3d 348; *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016); *June Med. Servs. L. L. C. v. Russo*, 140 S. Ct. 2103 (2020).

17. We also understand that both medication abortion bills have components that risk patient and provider privacy. S.B. 778 designates individual patient reports "public records." S.B. 778 § 8(H). Although S.B. 778 includes a vague disclaimer prohibiting the publication of "information or identifiers that would make it possible to identify, in any manner or under any circumstances, a woman who has obtained or seeks to obtain a chemical abortion," S.B. 778 § 8(C), this is a significant departure from existing law, which only publishes aggregated reports and has never made individual patient records "public records." S.B. 779 requires reporting annually of a "list of staff attending patients including licensing numbers and evidence of other qualifications." S.B. 779 § 9(A). Given the stigma and harassment faced by patients and providers, including the concerted efforts of anti-abortion activists to "out" abortion patients, OCRJ is very concerned that these requirements will risk patients' and providers' confidentiality and threaten their security.

18. OCRJ has served as a Plaintiff in two cases challenging other bills that regulated the manner and regimen of medication abortion—both bills were declared unconstitutional by the Oklahoma Supreme Court.[3]

19. Given the challenges that abortion patients face in the State—stigma, logistical barriers, societal and economic barriers, the COVID-19 pandemic—each of these laws would have a tremendous impact on Oklahomans.

20. The Challenged Laws will delay and deny access to abortion, which is essential to pregnant Oklahomans' ability to direct their own lives and form healthy families consistent with their values. The Challenged Laws are thus directly contrary to our purpose and mission.

[3] *Oklahoma Coal. for Reprod. Just. v. Cline*, 2019 OK 33, 441 P.3d 1145; *Oklahoma Coal. for Reprod. Just. v. Cline*, 2012 OK 102, 292 P.3d 27.

21. During this most recent legislative session, OCRJ marshalled its limited resources to combat the bills challenged in this case. We tracked the bills. Working with our coalition partners, we advocated against the bills. We lobbied legislators, and, for the first time, were able to persuade a member to read stories from abortion patients on the House floor. Even after hearing these stories from patients about how essential abortion was to their ability to determine the course of their health, lives, and families, the legislature passed the bills along with a "Trigger Ban," which bans abortion outright should *Roe v. Wade* be reversed by the Supreme Court. Since the bills passed, we have been speaking out about these bills and how they are each unjustified by any legitimate concerns about women's health, but rather motivated by a desire to ban abortion and burden abortion patients and providers.

22. Should these bills go into effect, we will do our best to continue to support Oklahomans who need access to abortion, but these bills will severely limit, if not outright prohibit, the availability of abortion care in the state. Our educational efforts will likely have to shift from educating people on how to obtain an abortion in Oklahoma[4] to how to access abortion care outside of Oklahoma. Because traveling out of state will be incredibly difficult, if not impossible, for many people, we will likely try to redirect our limited resources to help patients financially as they find ways to obtain care out of state. But these bills will destroy all that we have sought to protect.

23. When a patient is denied an abortion, their life is irrevocably altered—the State forces them to remain pregnant against their will and thereby trespasses on their bodily autonomy and intentions for their own life. This should not be.

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[4] *Supra* ¶ 8.

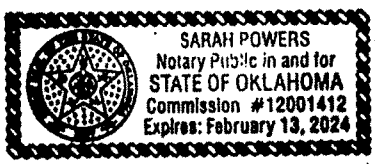
24. We understand that many places in this country are experiencing similar onslaughts on abortion care. To this we say: Oklahoma should be a state that zealously guards the individual liberty of all. We hope that a court of this State will step in to preserve this liberty.

DATED: August 31, 2021

Priya Desai

Priya Desai

NOTARY Sarah Powers



**IN THE DISTRICT COURT OF OKLAHOMA COUNTY**
**STATE OF OKLAHOMA**

OKLAHOMA CALL FOR REPRODUCTIVE JUSTICE, on behalf of itself and its members; TULSA WOMEN'S REPRODUCTIVE CLINIC, LLC, on behalf of itself, its physicians, its staff, and its patients; ALAN BRAID, M.D., on behalf of himself and his patients; COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, INC., on behalf of itself, its physicians, its staff, and its patients; and PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, on behalf of itself, its physicians, its staff, and its patients,

Plaintiffs,

v.

JOHN O'CONNOR, in his official capacity as Attorney General for the State of Oklahoma; DAVID PRATER, in his official capacity as District Attorney for Oklahoma County; STEVE KUNZWEILER, in his official capacity as District Attorney for Tulsa County; LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; KATIE TEMPLETON, in her official capacity as President of the Oklahoma State Board of Osteopathic Examiners; LANCE FRYE, in his official capacity as the Commissioner of the Oklahoma State Board of Health; and JUSTIN WILSON, in his official capacity as the President of the Oklahoma State Board of Pharmacy; as well as their employees, agents, and successors,

Defendants.

CASE NO._____

**AFFIDAVIT OF ALAN BRAID, M.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY INJUNCTION**

Dr. Alan Braid declares and states the following:

## I. Background

1. I am a board-certified obstetrician and gynecologist ("OB/GYN"), licensed to practice medicine in the states of Oklahoma and Texas. I am also the principal owner of Tulsa Women's Reproductive Clinic, LLC, an Oklahoma corporation, which operates a reproductive healthcare facility in Tulsa (the "Clinic"). I provide abortion services at the Clinic.

2. I have been providing reproductive healthcare, including abortion care, since 1978. I currently practice medicine in Texas and Oklahoma. I have been providing reproductive healthcare, including abortion care, in Oklahoma since September 2018 after I purchased the Clinic. I also provide abortion care at Alamo City Surgery Center PLLC d/b/a Alamo Women's Reproductive Services in San Antonio, Texas ("Alamo"). I am the co-owner of Houston Women's Reproductive Services in Houston, but I do not provide services there.

3. I graduated from the University of Texas Health Science Center at San Antonio with an M.D. in 1972. I completed my internship in obstetrics and gynecology at Bexar County Hospital District in 1973. I completed my residency in obstetrics and gynecology in 1976. I have extensive experience and training in reproductive healthcare, covering the full spectrum of care from obstetrics to abortion.

4. I am a Diplomate of the American Board of Obstetrics and Gynecology.[1] My full credentials are listed in my CV, which is attached hereto as Exhibit A.

[1] The American Board of Obstetrics and Gynecology (ABOG) board certifies obstetricians and gynecologists (OB/GYNS) in the U.S. and Canada. ABOG certifies as Diplomates those who obtain and maintain board certification. ABOG's certification standards are distinct from state licensure requirements and board certification and maintenance are voluntary. *See* Am. Bd. of Obstetrics & Gynecology, *Definition of an Obstetrician and Gynecologist*, https://www.abog.org/about-abog/policies/definition-of-an-obstetrician-and-gynecologist (last visited August 29, 2021).

5. I have read Oklahoma House Bills No. 1102 ("H.B. 1102"), No. 2441 ("H.B. 2441"), and No. 1904 ("H.B. 1904) and Oklahoma Senate Bills No. 778 ("S.B. 778") and No. 779 ("S.B. 779"), which were enacted during the 2021 Oklahoma legislative session. I submit this declaration in support of Plaintiffs' Motion for Temporary Injunction.

6. The facts and opinions I state here are based on my education and training, my nearly 5 decades of experience as a practicing physician specializing in the fields of obstetrics and gynecology, my review of the Clinic's business records, information obtained in the course of my duties at the Clinic, my review of scientific and medical literature and data, and personal knowledge that I have acquired through my work at and ownership and management of the Clinic.

## II. The Clinic

7. The Clinic is a medical practice in Tulsa, Oklahoma, which provides high-quality reproductive healthcare, including abortion services, to patients primarily from Oklahoma, as well as to patients who travel to Oklahoma from Texas, Missouri, Kansas, and Arkansas. Approximately five days per week, the Clinic provides medication abortion to patients up to 70 days or 10 weeks of pregnancy, as measured from the first day of a woman's last menstrual period ("LMP"). The Clinic also provides procedural abortion to patients up to 17 weeks and 6 days LMP approximately three days per week, typically on Wednesdays through Fridays. The Clinic also provides some non-abortion services, including the management of a miscarriage via medication or procedure, which is largely identical to abortion care, as well as hormonal oral and injection contraception.

8. The Clinic is certified by the National Abortion Federation (NAF) and licensed as an abortion facility by the Oklahoma State Board of Health. It also has Clinical Laboratory

Improvement Amendments (CLIA) certification. The Clinic's physicians and staff strive to provide only the best, evidence-based medical care to our patients.

9. I purchased the Clinic in 2018 and assumed clinic operations in August 2018; it had previously been in operation under a different name for over forty years. The previous owner was getting ready to retire, and I purchased the Clinic to ensure the Clinic's patients would continue to have access to abortion care.

10. The Clinic is one of only four facilities providing abortion in Oklahoma. There is one other clinic in Tulsa. Two clinics are located in Oklahoma City.

11. I have been traveling to Oklahoma to provide abortion care at the Clinic since September 2018. As the Clinic's principal owner, I handle personnel matters and the Clinic's business affairs. I also work with the Clinic's Medical Director to set policies and procedures for all medical care at the Clinic, including but not limited to patient education and counseling for medication abortions, in-clinic medication abortion care, and post-medication abortion follow up appointments and complications management. If any questions arise at the Clinic regarding a medical procedure, the Clinic's Medical Director and I resolve them together.

12. Five other physicians provide abortion care at the Clinic on a part-time basis. I and two other physicians—a board-certified OB/GYN and a board-certified family medicine physician—generally provide only medication abortion at the Clinic. Three additional physicians—one board-certified OB/GYN and two board-certified family medicine physicians—provide both medication and procedural abortions at the Clinic.

13. In 2019, the Clinic provided 2,879 abortions. In 2020, the Clinic provided 2,663 abortions. The first part of 2021 is on par with these earlier years.

14. Approximately 5,000 patients per year obtain an abortion in Oklahoma.[2]

## III. Overview of Abortion Care

15. Abortion is one of the safest and most common medical procedures performed in the United States.

16. There are generally two methods of providing abortion: procedural abortion[3] and medication abortion.

17. Procedural abortion involves the use of instruments or medications to gently dilate (open) the cervix and evacuate the contents of the uterus. Procedural abortion is a straightforward procedure; it is almost always performed in an outpatient setting and involves local anesthesia or, at times, conscious sedation to make the patient more comfortable. It is typically a one-day procedure at the Clinic. Some patients may need additional time for dilation and so may have to come back to the Clinic for a second day; this is not routine but is indicated on occasion.

18. The most common form of medication abortion is a regimen of two prescription drugs, mifepristone and misoprostol, taken orally. The patient first takes Mifepristone, which is also known by its commercial name of Mifeprex. Misoprostol, which is also known by its commercial name of Cytotec, is taken 24 to 48 hours after mifepristone and causes the uterus to contract and expel its contents.

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[2] Okla. State Dep't of Health, *Abortion Surveillance in Oklahoma: 2002-2020 Summary Report* (2020), https://oklahoma.gov/content/dam/ok/en/health/health2/aem-documents/data-and-statistics/center-for-health-statistics/2020%20AbortionReport.pdf.

[3] "Procedural" abortion is also referred to as "surgical" abortion, but abortion is not what is commonly understood to be surgery. There is no incision and no need for general anesthesia or a sterile field.

19. In 2019, 72% of the abortions the Clinic provided were medication abortions; in 2020, that percentage rose to 81%. We expect that 2021 will also have a high percentage of medication abortions.

20. According to data collected by the Oklahoma State Department of Health, the proportion of abortions by medication abortion in Oklahoma has been steadily increasing.[4] "In 2002, non-surgical abortions made up only 4.5 percent of all abortions performed in Oklahoma, while in 2020 non-surgical abortions made up 64.0 percent of all abortions."[5]

21. Abortion is safer than carrying a pregnancy to term. Complications from abortion occur less than 1% of the time and are lower than the rate of complications involved in carrying a pregnancy to term.[6] Nationally, the risk of death associated with childbirth is approximately 14 times higher than that associated with abortion, and pregnancy-related complications are more common with childbirth than abortion.[7]

## IV. Abortion is Essential Healthcare

22. Abortion is essential healthcare. I provide abortion care because I have seen over my decades of practice that abortion is essential for women's health and freedom. It enables women to direct their own lives and make decisions that are best for themselves and their families. Denying access to abortion would take that away. Abortion presents lower risks to patients than carrying a pregnancy to term.

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[4] *See supra* n.2.
[5] *Id.*
[6] Nat'l Acads. of Scis. Eng'g & Med., *The Safety and Quality of Abortion Care in the United States* (2018).
[7] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 (2 Part 1) Obstetrics & Gynecology 215 (2012), https://pubmed.ncbi.nlm.nih.gov/22270271/.

23. Our patients run the gamut of personal experience. We have patients who come from other states, already have children, have poor health, have had complications in prior pregnancies, and experience intimate partner violence, among many other types of patients. Most of our patients, however, are poor or low-income.

24. As a physician at the Clinic, I am familiar with the reasons why women seek our abortion services. While I feel it is my role to provide safe medical care without judgment and so generally would not ask patients why they are terminating a pregnancy, Oklahoma law requires me to do so. The reasons my patients share include, for example, that they have low incomes and/or already have children and feel they cannot adequately parent and support a child or additional children. Other patients seek abortion because continuing a pregnancy poses risks to their physical safety or health. Regardless of the specific circumstances underlying a patient's decision to have an abortion, most patients are sure of their decision by the time they arrive at the Clinic, and I do not begin an abortion procedure until I ensure that the patient is certain of their decision.

## V. Total Ban

25. I understand H.B. 1102 to define the provision of abortion care as "unprofessional conduct" for purposes of the Oklahoma Board of Medical Licensure and Supervision and of the Oklahoma State Board of Osteopathic Examiners, unless the abortion falls within a narrow exception.

26. I understand that continuing to provide abortion care if H.B. 1102 were to go into effect could lead to the suspension or permanent revocation of my license to practice medicine in Oklahoma, as well as fines. I understand that this could jeopardize my license to practice medicine in Texas as well.

27. I would not provide abortion care in violation of the total ban in light of these professional licensure and civil penalties.

28. If H.B. 1102 were to go into effect, it would cut off access to abortion care in Oklahoma entirely—forcing patients to attempt to seek care in another state if they are able or, for many patients, forcing them to carry their pregnancies to term.

## VI. 6-Week Ban

29. I understand that the 6-week ban turns on the detection of a "heartbeat" and prohibits performing or inducing an abortion "without first detecting whether or not [the] unborn child has a heartbeat." HB 2441 § 1(A). No abortion may be performed where a "heartbeat" has been determined to be "detectable." HB 2441 § 1(A). H.B. 2441 defines "detectable heartbeat" as "embryonic or fetal cardiac activity or the steady or repetitive rhythmic contract of the heart within the gestational sac." HB 2441 § 1(B).

30. In a typically developing embryo, cells that eventually form the basis for development of the heart later in pregnancy produce cardiac activity that is generally detectable via ultrasound beginning at approximately 6 weeks LMP, though I have seen cardiac activity prior to 6 weeks LMP. H.B. 2441 thus bans abortion in Oklahoma after approximately 6 weeks LMP.

31. The cells that produce this early cardiac activity have not yet formed a "heart." This activity is not a "heartbeat" in the lay sense, but, more accurately, electrical impulses present before development of the cardiovascular system. A developing pregnancy is properly referred to as an "embryo" until approximately 10 weeks LMP, when it becomes a "fetus." The Act forbids abortion even when cardiac activity is detected in an embryo.

32. No embryo is viable at approximately 6 weeks LMP. For context, full-term pregnancies usually last approximately 40 weeks LMP. Viability is generally understood in

medical science as the point in gestation when a fetus has a reasonable likelihood of survival outside of the pregnant woman.

33. The medical consensus is that viability typically occurs around approximately 23-24 weeks LMP.

34. I understand that H.B. 2441 imposes criminal homicide liability for provision of abortion after approximately 6 weeks LMP, unless the abortion falls within H.B. 2441's narrow exception. I would not provide abortion care in violation of this ban.

35. There are many reasons why patients may not be able to arrive at a clinic by approximately 6 weeks LMP. Some patients do not realize they are pregnant until after approximately 6 weeks LMP. This includes patients who have irregular menstrual cycles; have certain medical conditions such as obesity or diabetes; have been using contraceptives; are breastfeeding; or are experiencing bleeding during early pregnancy, a common occurrence that is frequently and easily mistaken for a period. Other patients may not develop or recognize symptoms of early pregnancy.

36. Even for the patients who do realize they are pregnant before 6 weeks LMP, they would have a very small window to obtain an abortion. For a patient with regular monthly periods, fertilization typically occurs at 2 weeks LMP (two weeks after the first day of their last menstrual period). Thus, even a woman with a highly regular, four-week menstrual cycle would already be 4 weeks LMP when she misses her next period, generally the first clear indication of a possible pregnancy.

37. If patients are prohibited from obtaining an abortion after approximately 6 weeks LMP, this gives them *one to two weeks at most* to decide they want an abortion, arrange all of the necessary logistics, gather the money, schedule the appointment, and wait 72 hours after receiving

state-mandated information as required by Oklahoma law. This will become even more difficult if S.B. 778's two-trip requirement—described more below—goes into effect.[8]

38. Many of our patients will not be able to obtain an abortion within this narrow window. According to the Department of Health data, from 2002-2018, only 39% of abortions took place under 6 weeks LMP. Thus, the 6-week ban will prohibit a large majority of abortions in Oklahoma.[9] Nationally, nearly two-thirds (63.8%) of abortions in 2018—the most recent year for which data is available—were performed after approximately 6 weeks LMP.[10]

39. The patients who can afford to do so will attempt to travel out of state. Those traveling out of state will need to pay additional travel and lodging costs and will likely face increased costs for the procedure. At later gestational ages, abortion is more expensive and may require a two-day procedure, instead of one. These patients would also experience increased risks to their health by the delay in access to abortion care.

40. For many patients, pregnancy creates serious symptoms and health risks. For people with comorbidities like asthma, hypertension, or diabetes, pregnancy exacerbates the symptoms and risk of an emergency. Even for people without comorbidities, common symptoms of pregnancy can include debilitating nausea, migraines, and dizziness. There is also a significant percentage of people who suffer perinatal depression or anxiety.

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[8] *Infra* Part VIII(B)(1).

[9] This data was derived from a tool maintained online by the Oklahoma State Department of Health. Okla. State Dep't of Health, *OK2SHARE*, https://www.health.state.ok.us/stats/Vital_Statistics/ITOP/Final/Statistics.shtml (last visited August 29, 2021). The most recent Abortion Surveillance Report only reports abortions performed after 8 weeks LMP.

[10] Ctrs. for Disease Control, *Abortion Surveillance—United States, 2018*, https://www.cdc.gov/mmwr/volumes/69/ss/pdfs/ss6907a1-H.pdf (Nov. 27, 2020).

41. Many of our patients will not be able to travel out of state to obtain an abortion. A significant percentage of the patients we see at the Clinic struggle to afford an abortion and receive some form of financial assistance. If these patients cannot access care at a clinic in Oklahoma, they may attempt to order pills through the mail to self-manage their abortions. We see patients who have attempted abortions themselves and failed, and the number of patients in this situation will only increase if H.B. 2441 takes effect.

42. If the 6-week ban takes effect, many of our patients will be forced to carry their pregnancies to term, having been denied the right to make decisions about their own bodies.

## VII. OB/GYN Requirement

43. I understand H.B. 1904 to require physicians providing abortions to be board-certified in obstetrics and gynecology.

44. Three of the Clinic's six physicians are not board-certified in OB/GYN. They are board-certified in family medicine.

45. These three physicians have years of experience providing abortion care.

46. There is no health or safety reason for requiring OB/GYN board-certification in order to provide abortion care. Board-certification in OB/GYN is not relevant to the safe provision of abortion services, and training in abortion care is not a required part of becoming a board-certified OB/GYN.

47. A variety of physicians can and do safely and routinely provide abortion care. When hiring physicians, I look to a provider's training and experience in order to determine their ability to provide abortion care.

48. H.B. 1904 singles out abortion care. I am not aware of a requirement like this for any other outpatient procedure in Oklahoma.

49. If H.B. 1904 were to go into effect, half of the Clinic's providers would have to immediately stop providing abortion care. This includes two of the three physicians who regularly provide procedural abortions later in pregnancy.

50. This would dramatically limit access to abortion care in Oklahoma.

51. In order to obtain board-certification in OB/GYN, the Clinic's board-certified family medicine physicians would have to go through four years of OB/GYN residency, among other requirements. It is therefore not feasible for our board-certified family medicine physicians to obtain another board certification to be able to provide abortion care at the Clinic.

52. The Clinic has had difficulty hiring physicians due to the stigma around abortion and the harassment of providers, nationally and in Oklahoma. It is therefore similarly not feasible to replace our existing board-certified family medicine physicians with board-certified OB/GYNs.

53. The Clinic's facility is regularly picketed by protestors who harass the Clinic's physicians, staff, and patients. I am aware that, across the United States, abortion providers are regularly subjected to harassment, threats, and acts of violence.[11] Physicians have been murdered simply because they provide abortions.[12] Anti-abortion groups have historically sought to obtain and post on the internet the home addresses of abortion providers, the names of their family members, and their personal phone numbers. This information is used to identify abortion providers and pressure them into no longer providing abortion care.

54. I have personally experienced harassment as a result of anti-abortion protestors and activists. For example, I have been followed home in my car and threatened by an anti-abortion protestor. I must now take extra precautions to make sure I am not being followed. Protestors often

[11] Nat'l Abortion Fed'n, *2019 Violence and Disruption Statistics* (July 30, 2020), https://prochoice.org/naf-releases-2019-violence-disruption-statistics/.
[12] *Id.*

picketed my former residence, disturbing my family and our neighbors with signs and shouting. The tires on my car were slashed by anti-abortion protestors while it was parked at that residence.

55. Oklahoma is already a hostile place for patients seeking abortion care and the physicians and medical professionals who provide it, even before the challenged legislation was enacted.

56. The stigma of providing abortion care can also make it difficult to maintain or find an outside practice. For these reasons, the Clinic has had particular difficulty hiring local physicians, and most of the Clinic's physicians travel from out-of-state to provide abortion care at the Clinic.

## VIII. Medication Abortion at the Clinic

57. I understand S.B. 778 and S.B. 779 to impose a host of onerous requirements that would drastically alter the Clinic's practices and limit access to abortion care.

### A. Practice at the Clinic

58. Medication abortions provided at the Clinic follow the Food and Drug Administration ("FDA") approved regimen of mifepristone and misoprostol.[13] The FDA has determined that this regimen is extremely safe and effective in terminating pregnancy—with a 97.4 percent overall success rate for terminating pregnancies up to 10 weeks LMP in the U.S.[14] I also understand that medical evidence supports the use of the regimen up to 11 weeks LMP.

59. I provide medication abortion to patients at the Clinic in accordance with the FDA's current label for mifepristone. I administer mifepristone to patients who take the pill orally while they are at the Clinic and then instruct them to take the misoprostol buccally 24 to 48 hours later

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[13] *FDA Label for Mifeprex*, https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf.

[14] *Id.*

at home or a location of their choosing. All physicians who provide medication abortion care at the Clinic follow this regimen, which has been shown to be extremely safe and effective.

60. Under Oklahoma law, one of the Clinic's physicians, or an agent of the Clinic's physicians, must provide specific state-mandated information to patients seeking abortion care at least 72 two hours before the patient's abortion procedure. This biased information must be given either by phone or in-person.[15] Either I or one of the Clinic's other physicians is available to answer questions from the patient when the patient receives this information.

61. When patients arrive at the Clinic for an abortion, they undergo an ultrasound to confirm the gestational age of the pregnancy, have some lab tests, and receive counseling on the risks, benefits, and alternatives to abortion and the types of abortion procedures for which they are eligible. No abortion procedure begins until the patient has reviewed all of her options; received relevant, evidence-based information about the procedure; and provided informed consent to the procedure.

62. If a patient is eligible for and decides she wants a medication abortion, the patient is given a link to a video that further explains how the medications work, directions for taking the medications, and what to expect.

63. Medication abortion patients then meet with the providing physician, who will again explain the process, the medications used, the indication and precautions, and the treatment plan and go over any questions.

64. On the day they come in for their appointment, medication abortion patients are scheduled for a 7-14 day follow-up with a physician, though they are also able to contact the on-

[15] 63 O.S. §§ 1-738.2-3.

call nurse at any time if they have any questions or concerns. If the patient does not show up for the follow-up appointment, the Clinic attempts to contact the patient.

65. In my experience, many women prefer medication abortion. Some patients prefer medication abortion because they can complete the process in the privacy of their homes, with the company of loved ones, at a time of their choosing. Other patients, including rape survivors, prefer medication abortion to a procedural abortion because they fear a procedure involving the insertion of instruments.

66. Medication abortion can also be medically preferred for some patients. For example, some women have medical conditions that make medication abortion a safer option, with a lower risk of complications and failure than procedural abortion. These conditions include anomalies of the reproductive and genital tract, such as large uterine fibroids, or physical conditions such as obesity. Such conditions are common in my experience.

**B. Effects of S.B. 778 and S.B. 779**

67. Given their sweeping nature, it is difficult to determine the full scope of the effects of these bills, but I have identified below some of the provisions that will be particularly problematic for patients and the Clinic.

68. If the Clinic, the Clinic's providers, and I are not able to comply with each and every provision, we will be barred entirely from providing medication abortion. Given the safety of medication abortion, there is no justification for these intrusive schemes that would essentially overhaul the way we provide medication abortion—imposing significant delays and other logistical burdens on patients and reducing access to abortion in Oklahoma.

**1. S.B. 778**

69. I understand S.B. 778 to impose dozens of medically unnecessary requirements, but these are some that I find particularly alarming:

70. **Two-Trip Requirement**: I understand S.B. 778 requires patients to have an ultrasound as part of the mandatory disclosures that must be given at least 72 hours prior to a medication abortion. Unless the patient obtains an ultrasound elsewhere from a reliable provider,[16] this provision will require patients to make an additional—and medically unnecessary—visit to the Clinic for a medication abortion.

71. We also provide ultrasounds that are very reasonably priced because most of our patients are poor or low-income. Given the challenges our patients face in covering the cost of services, obtaining an ultrasound closer to their home might not be feasible because it will involve more expense.

72. Having to come to the Clinic twice for a medication abortion would be highly problematic for many patients, especially those who are hourly employees. One of the questions I hear most often from my patients about having an abortion is "when can I go back to work?" I believe that it would be difficult for some of my patients to have to get time off work or make other arrangements, such as finding childcare, so that they can make an additional visit to the Clinic.

73. This additional visit will also be especially harmful for women who travel long distances to get to the Clinic and will have to travel twice if S.B. 778 goes into effect.

[16] I am particularly concerned about women obtaining ultrasounds from crisis pregnancy centers ("CPCs"), where they may be given inaccurate information about the gestational age of their pregnancy in an effort to delay them from seeking abortion care. This could cause women to miss the window for their preferred abortion method or to access abortion altogether—particularly if the 6-week ban goes into effect. In my practice, I routinely see patients who have been mis-dated at CPCs.

74. The two-trip requirement will compound existing obstacles, leading to further delays and barriers that may be insurmountable for some patients.

75. Given that medication abortion is only available at the Clinic up to 10 weeks LMP, I am very concerned patients will miss that window, including patients who prefer medication abortion or for whom medication abortion is medically indicated.

76. Providing this additional, medically unnecessary ultrasound would disrupt scheduling and create backlogs that will delay care. The Clinic would need to either hire additional staff or shift time away from patient care. This could limit access to abortion care, particularly if the mandatory disclosures, including the ultrasound, must be provided by a physician.

77. There is no health or safety reason for this requirement. Patients coming to the Clinic for a medication abortion already receive an ultrasound at the Clinic on the day of their appointment. Depending on where and when a patient gets the ultrasound as part of the mandatory disclosures, as well as the gestational age of the pregnancy, the patient may still need another ultrasound on the day of the medication abortion.

78. **Reporting Requirements:** I understand S.B. 778 requires for each medication abortion the identification of physicians providing medication abortion and referring providers, in addition to other information:

- Identity of qualified physician;
- Whether the medication abortion was completed at hospital/facility or alternative location;
- Referring physician, agency or service, if any;
- Pregnant patient's age and race;
- Number of previous pregnancies, live births, previous abortions;
- Probable gestational age;
- Drugs used, date provided, reason for abortion;
- Preexisting medical conditions which would complicate pregnancy;
- Whether patient returned for follow-up;
- Whether patient suffered from any complications; and
- Amount billed for complications.

79. I understand it to also designate the individual patient reports containing this information as "public records." S.B. 778 § 8(H). My understanding is that existing law only publishes aggregated reports and has never made individual patient records "public records."

80. Although S.B. 778 includes a vague disclaimer that "information or identifiers that would make it possible to identify, in any manner or under any circumstances, a woman who has obtained or seeks to obtain a chemical abortion," S.B. 778 § 8(C), I have serious concerns that this law will risk the confidentiality of patient information. The information contained in these reports would expose a host of information about patients, including age, number of previous pregnancies, and pre-existing medical conditions. S.B. 778 § 8. These data could be used to identify individual patients even without other identifiers. This is particularly dangerous in the context of abortion, where abusive partners of pregnant women may seek to access patient information.

81. There is no protection for the identity of providers and referring providers, which must be reported. S.B. 778 § 8. This requirement will make it easier for people opposed to abortion to identify and harass abortion providers and referring providers. The requirement to report the name of a referring physician who may or may not be an abortion provider could also stop such physicians from referring their patients to the Clinic.

**2. S.B. 779**

82. I understand S.B. 779 to require any physicians providing medication abortion to register with the State, even though physicians at the Clinic are already licensed to practice medicine in Oklahoma. Like S.B. 778, S.B. 779 imposes a host of medically unnecessary requirements.

83. **Hospital Admitting Privileges:** I understand S.B. 779 to require a physician providing medication abortion to maintain hospital admitting privileges at a hospital in the county

or contiguous county where the medication abortion is provided—and to inform the patient of any hospital where the physician holds admitting privileges—or to enter into a written agreement with another physician. S.B. 779 § 8, § 7(11). If a physician opts for a written agreement with an associated physician, my understanding is that the associated physician must have admitting privileges and their agreement must meet a host of other conditions. S.B. 779 § 8.

84. There is no health or safety benefit to requiring admitting privileges as a condition for providing medication abortion.

85. Having hospital admitting privileges is not related to competence in providing abortion care. I do not think it is necessary to hold admitting privileges in Oklahoma because I do not treat patients in a hospital setting. Like physicians in other practice areas, I am able to recognize complications and make the determination of when to treat a patient in the Clinic and when to refer the patient to a hospital.

86. Additionally, complications from medication abortion are rare and, when they do arise, they generally occur after the patient has left the Clinic. The patient ingests the first medication, Mifepristone, at the Clinic, but takes the second medication, Misoprostol, at a location of their choosing.

87. The Clinic already has a protocol for how to handle complications, including in the rare event when a patient must be transferred.

88. Four of the Clinic's physicians, including myself, travel from out of state to provide care at the Clinic, making it even more difficult—if not impossible—for us to obtain privileges at a local hospital.

89. Further, it is unclear whether the Clinic would be able to find a local physician who would be willing to enter into an agreement like this. I am not aware of any physicians in Tulsa

who would be willing to enter into an agreement for purposes of this requirement, particularly in light of the stigma and harassment abortion providers face.[17]

90. I understand the law to require the providing physicians to submit a copy of the agreement to the State, which then submits a copy of that agreement to each hospital in the county. S.B. 779 § 8(2). Given the stigma of providing abortion care, this may exacerbate the difficulty of finding a provider willing to enter into such an agreement.

91. Accordingly, this requirement would immediately limit access—causing delays and preventing some patients from accessing their preferred abortion method.

92. **Reporting System**: I understand S.B. 779 § 9(A) to require the Oklahoma Board of Medical Licensure and Supervision and Oklahoma State Board of Osteopathic Examiners to create an electronically based reporting system for certified physicians to report annually certain information, including:

- The number of patients served;
- Age of patients served;
- Race of patients served;
- County and state of residence of patients served;
- If the patient resides outside the United States, city and country of residence;
- County and state of service;
- A list of staff attending patients including licensing numbers and evidence of other qualifications;
- Each medication used or provided per patient, by date;
- Any known complications or adverse events, and how they were addressed, by date; and
- Unresolved cases.

93. I understand this reporting system is "also [to] be used by emergency department physicians and private physicians who treat post-abortion complications." S.B. 779 § 9(B).

[17] *Supra* Part VII.

94. I understand S.B. 779 contains language requiring physicians to protect any personally identifiable information from disclosure, S.B. 779 § 9(C), but I have concerns that such a reporting system raises confidentiality concerns for my patients and the Clinic's physicians and staff.

95. **Complaint Portal**: I understand S.B. 779 to also direct Oklahoma's physician licensing boards to develop a "complaint portal" for patients, pharmacy, nursing and medical professions, and the public to submit information about potential violations. S.B. 779 § 13(B). I understand S.B. 779 to require the names of all the fully licensed physicians certified under Oklahoma's medication abortion program to be listed on this portal. S.B. 779 § 13(D).

96. Given the threats of harassment and violence against abortion providers, I have serious concerns about listing the names of medication abortion providers in this way.

## IX. Conclusion

97. The Acts carry criminal, civil, and professional licensure penalties. Should they go into effect, they Clinic and I will not provide care in violation of them.

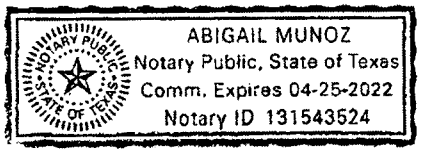
98. Each of the total ban, 6-week ban, and OB/GYN requirement would immediately dramatically reduce, if not eliminate entirely, access to abortion in Oklahoma if it were to go into effect, and the medication abortion bills would impose a host of requirements that add additional obstacles, cause delays, and likely push medication abortion out of reach for some patients. This reduced access will delay care, forcing some people to have abortions later in pregnancy and preventing others from accessing care altogether.

I declare under penalty of perjury that the foregoing is true and correct.

Dated this 31 day of August, 2021.

Alan Braid, M.D.

NOTARY



# EXHIBIT A

# ALAN RICHARD BRAID, M.D.

BOARD CERTIFIED OBSTETRICS AND GYNECOLOGY

DIPLOMATE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

1963 Weequahic High School, Newark, N.J.

1967 Pennsylvania State University B.S

1972 University of Texas Health Science Center, M.D.

1972-1976 UTHSCSA residency Obstetrics and Gynecology

1976-1978 Dover Air Force Base, Rank of Major, Ob-Gyn Service

1978-2010 Private practice Ob-Gyn, San Antonio, Texas

2010-2012 Owner and Medical Director, Reproductive Services of San Antonio

2012-present Owner and Medical Director, Alamo Women's Reproductive Services

2015-present Owner and Medical Director, Alamo City Surgery Center, San Antonio, Texas

2018-present Owner, Tulsa Women's Reproductive Clinic, Tulsa, Oklahoma

**IN THE DISTRICT COURT OF OKLAHOMA COUNTY**
**STATE OF OKLAHOMA**

OKLAHOMA CALL FOR REPRODUCTIVE JUSTICE, on behalf of itself and its members; TULSA WOMEN'S REPRODUCTIVE CLINIC, LLC, on behalf of itself, its physicians, and staff; ALAN BRAID, M.D., on behalf of himself and his patients; COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, INC., on behalf of itself, its physicians, and staff; and PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, on behalf of itself, its physicians, and staff,

Plaintiffs,

v.

JOHN O'CONNOR, in his official capacity as Attorney General for the State of Oklahoma; DAVID PRATER, in his official capacity as District Attorney for Oklahoma County; STEVE KUNZWEILER, in his official capacity as District Attorney for Tulsa County; LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; KATIE TEMPLETON, in her official capacity as President of the Oklahoma State Board of Osteopathic Examiners; LANCE FRYE, in his official capacity as the Commissioner of the Oklahoma State Board of Health; and JUSTIN WILSON, in his official capacity as the President of the Oklahoma State Board of Pharmacy; as well as their employees, agents, and successors,

Defendants.

**CASE NO._____**

**DECLARATION OF JOSHUA YAP, MD., MPH., AAHIVS**
**IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY INJUNCTION**

Joshua Yap, M.D., MPH, AAHIVS, declares the following under penalty of perjury:

1. I am employed by and provide health care services at Plaintiff Planned Parenthood Arkansas & Eastern Oklahoma ("PPAEO")'s Tulsa, Oklahoma health center. I also provide health care services on a regular basis at Plaintiff Comprehensive Health of Planned Parenthood Great Plains, Inc. ("CHPPGP")'s Oklahoma City health center. I submit this declaration in support of Plaintiffs' Motion for Temporary Injunction to enjoin enforcement of Oklahoma House Bills No. 1102 ("H.B. 1102" or "Total Ban"); No. 2441 ("H.B. 2441" or "Six Week Ban"); Oklahoma Senate Bills No. 778 ("S.B. 778") and No. 779 ("S.B. 779") (collectively, "Medication Abortion Restrictions"); and Oklahoma House Bill No. 1904 ("H.B. 1904" or "OB/GYN Requirement") (collectively, "the Challenged Laws"), which were enacted during the 2021 Oklahoma legislative session.

2. I am a board-certified Family Medicine physician and am licensed to practice medicine in Oklahoma, Kansas, Arkansas, Missouri, and California. I graduated from medical school at Loma Linda University in 2015. I completed my internship and dual residency in Family Medicine and Preventive Medicine at Montefiore Medical Center and Albert Einstein College of Medicine in 2019. I obtained my Master of Public Health degree in 2019 from the City University of New York School of Public Health.

3. I am familiar with the Challenged Laws' requirements. The effect of these laws would be devastating to my patients' ability to exercise their constitutional right to choose abortion and prevent PPAEO and CHPPGP (collectively, "Planned Parenthood Plaintiffs"), and me personally, from being able to fulfill our mission of providing high-quality, safe, and effective health care to the over 1,300 patients who obtain abortion care from Planned Parenthood Plaintiffs in Oklahoma each year.

## Planned Parenthood Plaintiffs' Health Centers' Provision of Abortion Care

4. I am employed by and provide health care at PPAEO's Tulsa health center and I also provide care at CHPPGP's Oklahoma City health center.

5. Planned Parenthood Plaintiffs' Oklahoma health centers provide a broad range of sexual and reproductive health care and education services, including abortion care, contraception care and counseling, pregnancy testing and prenatal referrals, testing and treatment for sexually transmitted infections, PrEP, PEP, clinical breast exams, breast and cervical cancer screenings, colposcopies and biopsies, condyloma treatment, and gender-affirming hormone therapy and hormone replacement therapy.

6. Our health centers provide procedural abortion care[1] for patients through approximately 17 weeks gestational age, as measured from the first day of a patient's last menstrual period ("LMP"), and medication abortion up through 77 days gestational age.

7. Both of our health centers are licensed by the Oklahoma State Department of Health. Our health center labs have Clinical Laboratory Improvement Amendments (CLIA) certification. Both health centers also keep prescription pharmaceuticals in a drug room licensed by the Oklahoma State Board of Pharmacy.

## Our Patients

8. Our patients seek abortion care for a variety of reasons, including, for example, being unable to divert time, financial resources, or caretaking resources away from existing children or other family members; being unable to absorb the additional financial burden; having become pregnant as the result of rape; having an abusive partner; being unable to take time away

[1] This is also sometimes referred to as "surgical abortion," though it does not involve making any incisions.

from their educational or career paths; being in the military and on the cusp of deployment; and medical reasons, including, for example, a fetal diagnosis, a history of previous high-risk pregnancies, or cancer diagnosis that requires choosing between effective treatment and pregnancy.

9. Most of our patients are firm in their decision when they come to us. We only provide abortion care to patients when we are confident that they are certain that abortion is the right option for them and after obtaining their informed consent. Our patients undergo an informed consent process that includes an explanation and discussion of the methods of abortion and their respective risks and benefits, as well as alternatives to abortion, such as parenting and adoption. We also answer any questions the patient has. At every step of the process, we make sure our patients know that we support them and their decision, whatever it may be. After a patient obtains an abortion, that patient is sent home with discharge instructions and information about how to contact us 24/7 with any concerns or questions. We try to follow up with all medication abortion patients to see how they are doing, answer any questions, and determine whether further follow-up care is needed.

10. At least 30% of our patients live near or below the federal poverty line and many more are low-income. As a result, laws that restrict or impose barriers on access to abortion disproportionately affect people who have the fewest resources to find alternate ways to obtain the care they need or to overcome barriers to access.

11. According to the American Community Survey conducted by the U.S. Census Bureau, Black Oklahomans are more than twice as likely to live in poverty (28.2%) than their white counterparts (12.6%).[2]

12. According to the Oklahoma State Department of Health, Black women also access abortion care at higher rates than their white counterparts.[3] This trend holds true for people obtaining abortions at Planned Parenthood Plaintiffs' Oklahoma health centers.

13. Thus, any laws that restrict or impose barriers on access to abortion disproportionately affect Black people in Oklahoma who both access abortion services at a higher rate and have fewer resources to find alternate means of finding care or overcoming barriers to abortion access.

14. Many of our patients already have a difficult time accessing abortion care. Many have difficulty obtaining the funds for an abortion, obtaining transportation to a health center (particularly as Oklahoma has virtually no public transportation outside its major cities), being able to get and afford to take a day off from work, and finding childcare for existing children.

15. All of these logistics need to be arranged before a patient can obtain an abortion and that all takes time. Moreover, the State of Oklahoma already requires my patients to wait at least 72 hours before they can obtain an abortion. Adding to the logistical obstacles patients need to overcome to access an abortion will simply worsen and compound the delays they already face.

16. Abortion is a time-sensitive medical procedure. Delays can result in patients being pushed past the point when they can obtain a medication abortion, even if that would be the

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[2] United States Census Bureau, *Poverty Status in the Past 12 Months, 2019 Community Survey 1-year estimates* (2019), https://data.census.gov/cedsci/table?q=oklahoma%20poverty%20race&tid=ACSST1Y2019.S1701

[3] Oklahoma State Department of Health, *Abortion Surveillance in Oklahoma, 2002–2019 Summary Report* 7 (2019), https://www.ok.gov/health2/documents/2019%20ITOP%20Report.pdf

preferable method for that patient. Delays can also push patients beyond the point at which they can obtain abortion care at all in Oklahoma.

**Our Providers**

17. I have provided abortion care for five years. I obtained training in abortion care during my dual residency at Montefiore Medical Center and Albert Einstein College of Medicine, as well as during an extended training in abortion care in Illinois and in Texas.

18. I have been providing health care services, including abortion care, at CHPPGP's Oklahoma City health center since August of 2019.

19. Over time, CHPPGP was able to hire other physicians to provide care in Oklahoma City, though all are out-of-state doctors who travel to Oklahoma to provide care a few days each per month.

20. I trained and onboarded many of the physicians providing care at CHPPGP's Oklahoma City health center, including ensuring their practical competency in providing abortion care.

21. Once other physicians began providing abortion care in Oklahoma City, I was able to begin providing care at PPAEO's Tulsa health center, where I am the only physician who provides abortion care. Starting in September, I will resume providing care in Oklahoma City a few days per month.

**Difficulty Finding Providers**

22. We have faced many challenges hiring physicians willing to provide health care in Oklahoma. During 2019 and the beginning of 2020, while I was the sole Planned Parenthood provider in Oklahoma, we sought to hire physicians who lived in or were willing to move to

Oklahoma to provide care at CHPPGP's Oklahoma City health center full-time. We were unable to find a single physician willing to do so.

23. There are many reasons why physicians are hesitant to provide abortion care in Oklahoma, including fear of harassment by anti-abortion protestors. Some of the physicians with whom Planned Parenthood met regarding the Oklahoma City position expressed specific concerns about security, harassment of themselves or family members, and potential stigma from future employers in Oklahoma.

24. I have first-hand experience with such harassment. For example, around March of this year, an anti-abortion protester would pace outside one of our health centers with a large rifle slung over his shoulder, apparently trying to film staff and patients as they walked into and out of the health center. We were forced to use large umbrellas to escort our patients inside and shield their faces to protect their privacy.

25. In another instance earlier this year, someone followed my car out of the clinic. I had to drive around the block in circles until the car stopped following me, for fear that the protestors were trying to follow me home to find out where I live.

26. In Oklahoma City, we have been forced to call the police because anti-abortion protesters were attempting to film patients inside the health center through the windows. We have also had a protester dressed as the grim reaper scare patients as they entered the health center. Our nearby facility in Edmond, which does not provide abortion services, was vandalized in October 2020.

27. Though we were unable to secure full-time physicians for our Oklahoma City health center, we are lucky enough to have found physicians willing to travel into Oklahoma from

out-of-state to provide abortion care. As a result, I have time to provide care to more patients in Tulsa.

28. As discussed in more detail below, none of our providers have admitting privileges in Oklahoma City. Only one of our providers in either location is a board-certified OB/GYN, and she provides care in Oklahoma only a few days per month.

**Total Ban**

29. I understand that the Total Ban mandates medical licensure penalties for a physician who provides an abortion—at any stage of pregnancy and for any reason except for an exceedingly narrow set of exceptions for life-threatening medical conditions. These penalties include, at minimum, a one-year licensure suspension, along with possible fines.

30. The Planned Parenthood Plaintiff health centers in Oklahoma have cared for over 1,300 patients already this calendar year—that is 1,300 people who would have been barred from accessing abortion care in Oklahoma under this law.

31. If the Total Ban were to take effect and abortion services were to become unavailable in Oklahoma, people would be forced to seek abortion care out of state or would be forced to carry their unwanted pregnancies to term, including potentially high-risk pregnancies. Some may seek to terminate their pregnancies outside the medical system altogether.

32. Many of our patients will have a difficult, if not impossible, time traveling out of state, particularly those living with abusive partners or abusive parents, and those who already struggle to travel to an in-state clinic because of financial or logistical hurdles.

33. Traveling out of state will only compound the existing barriers to accessing care my patients already face and may well result in substantial delays in obtaining care.

34. Many of the states contiguous to Oklahoma, including Texas, Arkansas, and Missouri, have passed near-total abortion bans, highlighting the importance to my Oklahoma patients of being able to obtain safe, legal abortion care within their home state.

**Six Week Ban**

35. I understand the Six Week Ban defines as homicide the provision of abortions performed where embryonic cardiac activity is detectable by ultrasound, which is generally around six weeks gestation, long before the embryo develops into a fetus that is viable (i.e., that can sustain life outside of the uterus).

36. The majority of our abortion patients are later than six weeks gestation when we see them. This is because many patients do not yet know that they are pregnant at six weeks gestation. Symptoms of pregnancy, including nausea and missed periods, are not present or consistent among all patients, nor are they always related to pregnancy (meaning a patient, given their medical history, may not have reason to believe that a particular symptom, such as nausea or a missed period, necessarily means they are pregnant; for example, many patients have irregular periods and some do not get periods at all). And, even for those who do know they are pregnant, it is often not possible to immediately obtain an appointment and travel to one of our health centers.

37. Thus, the Six Week Ban would have a devastating effect on most of our patients, denying them the ability to seek safe, legal abortion care in their home state, forcing them to either travel out of state or to continue with an unwanted pregnancy, even for those with potentially high-risk pregnancies.

**OB/GYN Requirement**

38. I am board certified in Family Medicine. I am not board-certified in Obstetrics and Gynecology.

39. I obtained substantial abortion training during my residency in New York City, and further advanced training at abortion centers in Illinois and Texas. I completed multiple rotations in abortion care, including an extended rotation in second trimester abortion care. I also completed rotations in labor and delivery and outpatient OB/GYN care.

40. I oversaw much of the training and onboarding for all but one of the physicians who provide abortion care at Planned Parenthood Plaintiffs' Oklahoma health centers. As with all of the physicians we hire, these physicians all had prior training and experience in abortion care, and we ensured their competency in abortion before they were privileged to provide such care to patients, as is our practice.

41. As discussed above, aside from the one physician who is a board-certified OB/GYN and provides care at CHPPGP's Oklahoma City health center on only a part-time basis, the other providers at that health center, including myself, are all board-certified in Family Medicine.

42. There is no medical reason to restrict the provision of abortion care only to physicians who are board-certified in Obstetrics and Gynecology.

43. I am not aware of any specialized abortion care training that a board-certified OB/GYN obtains that I did not obtain during my residency as a Family Practice physician.

44. Abortion complications are rare. However, as in any medical practice, some complications may arise that may require referral to another provider. Though I have never needed to do so in my own practice, in the event that a complication arose that would require referral to another physician, any family medicine physician could make such a referral.

45. The same and similar methods of abortion care provided to patients seeking an induced abortion (*i.e.*, people who seek to terminate a pregnancy) are routinely provided to patients

experiencing a spontaneous abortion (*i.e.*, people experiencing a miscarriage). There is no medical reason to require different qualifications to provide that care to one set of patients than to another.

46. If the OB/GYN Requirement went into effect, Planned Parenthood Plaintiffs would immediately become unable to provide abortion care to the vast majority of our patients in Oklahoma. I do not know when, if ever, we would be able to hire sufficient OB/GYNs willing to provide in Oklahoma to be able to serve the number of abortion patients we are currently serving. The care provided by the one OB/GYN who currently travels to Oklahoma only a few days per month is extremely limited because of her commitment to patients in other states.

47. Obtaining board certification in Obstetrics and Gynecology does not simply involve preparing for and taking the board exams, though just taking the exams alone would also be onerous and would take me away from my patients. Board certification requires that, in order to be eligible to take the board exams, one must complete a certain number of years training in the specialty in question through a residency certified in the relevant specialty. In essence, I would have to apply to, be accepted to, and then complete another medical residency, which would take years.

48. As noted above, if the OB/GYN Requirement were to go into effect, Planned Parenthood Plaintiffs would have to turn away the vast majority of abortion patients we currently see.

**Medication Abortion Restrictions**

49. I understand S.B. 778 and 779 ("Medication Abortion Restrictions") to impose a host of restrictions on the provision of medication abortion care, creating various qualification and certification requirements for doctors, pharmacies, and pharmaceutical manufacturers, as well as detailed and onerous reporting requirements. Specifically, I understand that S.B. 778 requires,

among other things, that people must obtain an ultrasound at least 72 hours prior to obtaining an abortion; and that S.B. 779 (the physician, manufacturer, and pharmacy certification bill) requires, among other things, that physicians who provide abortions must have admitting privileges at a nearby hospital or a written agreement with a physician who does. I also understand that S.B. 779 prohibits the provision of medication abortion beyond 70 days gestational age.

50. Patients at or less than 77 days gestation who are seeking an abortion at one of our Oklahoma health centers may choose either a medication abortion or an in-clinic abortion. Medication abortion involves taking two medications: mifepristone, which disrupts the development of the pregnancy, and misoprostol, which causes the uterus to contract and the pregnancy to be passed in a manner similar to a miscarriage.

51. By contrast, in-clinic abortions at this stage in pregnancy involve gently opening the cervix and using light suction to empty the contents of the uterus (generally referred to as "aspiration").

52. Medication abortion is safe and effective, with an over 97% effectiveness rate for pregnancies up to 77 days gestational age.[4]

53. Many of my patients who can choose to have either an in-clinic or medication abortion prefer medication abortion. Some patients indicate a preference for medication abortion because: it feels more natural to them as it works much like a miscarriage; they can choose where and when (within 48 hours of taking the first medication) to take the second medication; they may prefer the option of being able to do it in the comfort of their own homes, on their own schedules; and they may have experienced sexual assault or other trauma or suffer from vaginismus and would

[4] National Abortion Federation, *Clinical Policy Guidelines for Abortion Care* 18 (2020), https://5aa1b2xfmfh2e2mk03kk8rsx-wpengine.netdna-ssl.com/wp-content/uploads/2020_CPGs.pdf

like to avoid to the extent possible having speculums and other instruments inserted in their vaginas.

54. In 2021 so far, approximately 85% of abortions obtained at Planned Parenthood Plaintiffs' Oklahoma health centers have been medication abortion.

55. If the Medication Abortion Restrictions went into effect, even if abortion were otherwise legal in Oklahoma, the vast majority of our patients would be affected, and some would potentially be prevented from obtaining the method of abortion that is right for them. *None* of our patients would be able to obtain a medication abortion after 70 days gestation, despite the fact that evidence-based clinical practice permits its use up to 77 days.[5]

56. While I will attempt to illustrate the devastating effects the Medication Abortion Restrictions would have on the provision of abortion care in Oklahoma, as detailed below, the maze of requirements in the bills likely will have many more wide-ranging effects than I have been able to fully illustrate here. For example, S.B. 779 requires certain pharmaceutical manufacturers of abortion-inducing drugs to register with the state of Oklahoma and submit to audits, which may imperil the availability of medication abortion in Oklahoma entirely if manufacturers are unable or unwilling to obtain such certification or submit to the required audit. The Medication Abortion Restrictions also include arduous reporting requirements, some of which are to be designated "public records," which require such detailed information about a patient's medical history that patients may be identifiable, which may put some patients at risk from abusive partners or family members. These reporting requirements also require abortion providers to identify any physician or agency who referred a patient to us, which may subject those physicians and agencies to threats and harassment and may ultimately create a chilling effect where physicians and agencies are

[5] National Abortion Federation, *supra* note 4.

unwilling to refer patients to abortion providers, even at a patient's request or when doing so is in the patient's best interest.

57. Thus, while there are likely to be many more effects of the Medication Abortion Restrictions than I can list here, I will attempt to describe some of the Medication Abortion Restrictions' requirements that will have the most devastating impact on access to abortion in Oklahoma.

**Two Trip Requirement**

58. I understand that S.B. 778 would require medication abortion patients to obtain an ultrasound at least 72 hours prior to obtaining an abortion. For most patients, this would mean two trips to our health centers, which will double the travel, financial, and logistical burdens already experienced by our patients. Indeed, even patients who do live near our health centers will face logistical challenges, potentially needing to take two days off from work or arrange childcare on two different days.

59. There is no medical reason for a patient to obtain an ultrasound prior to the day of their abortion. The language of S.B. 778 indicates that this ultrasound is intended to "confirm gestational age," but there is no reason that this needs to occur prior to the day of the abortion. We already confirm the gestational age of our patients' pregnancies on the day of their medication abortion.

60. The majority of our abortion patients who reside in Oklahoma do not live in the same city as the health center where they obtain abortion care, and many live in rural areas. As a result, travel to and from our health centers can often be difficult for patients, both because of the time they must spend travelling to the health center, as well as the associated logistical hurdles of taking time off from work, obtaining transportation, and obtaining childcare.

61. Moreover, the logistical issues of adding a medically unnecessary appointment would affect all of our clinical processes. Our health centers would have to accommodate twice the number of appointments per patient—one for the ultrasound and one at least 72 hours later for the abortion. In order to maintain the same availability of care to patients, front desk staff would have to check in and assist patients for twice the number of appointments per abortion patient. Waiting rooms would be filled with patients there only for medically unnecessary ultrasounds.

62. If S.B. 778 goes into effect, some patients will be required to obtain two ultrasounds if patients experience a delay of more than seven days between their statutorily required ultrasound and the day of their actual abortion. If more than seven days have elapsed since an ultrasound, our procedures require the patient to obtain a second ultrasound.

63. If the Six Week Ban were also to go into effect, then those patients who are delayed past six weeks—because of the logistical burdens of having to come to the health center twice and/or because of congestion at the health center caused by the 72-hour ultrasound requirement—would be denied care in Oklahoma entirely, forcing them to seek care out of state or forego care entirely, carrying an unwanted pregnancy to term or seeking a pregnancy termination outside the medical system.

64. The delays would also cause some patients who would otherwise be eligible for a medication abortion to be delayed beyond the window in which we provide it at our health centers (currently up to 77 days gestation, reduced to 70 days if S.B. 779 is permitted to go into effect) and would thus lose the option of obtaining a medication abortion in Oklahoma.

65. Similarly, some patients who are currently able to obtain an abortion at one of our Oklahoma health centers may well be so delayed that they will be beyond the stage in pregnancy where we provide care in Oklahoma. This would require these patients to overcome yet more

logistical and financial hurdles including finding overnight lodging near an out-of-state health center.

**Admitting Privileges Requirement**

66. I understand that S.B. 779 would prohibit a physician from providing medication abortion to patients unless the physician either has admitting privileges at a hospital in the same or contiguous county where the medication abortion is provided or has a written agreement with a physician who does.

67. There is no medical reason for this requirement.

68. I have never had to transfer any abortion patient from a health center to a hospital. This is not surprising as both medication and in-clinic abortion methods are safe and highly effective.

69. Moreover, because medication abortion involves completing the abortion outside of the health center (after the second medication is taken), even if a patient were to suffer a complication, it would almost certainly not occur at the time the patient takes the first medication at the health center.

70. All medication abortion patients are advised in their discharge papers to contact us, if they have any questions or concerns after they have left one of our health centers and are given contact information to reach us 24/7. If such a patient calls during clinic hours, the patient will be offered an appointment as soon as possible (usually a same- or next-day appointment), or if we believe they need more immediate attention, we will refer them directly to a hospital, as discussed below. If they come into the health center, we speak to and examine the patient, answer any and all questions, and provide follow-up care as appropriate.

71. If a medication abortion patient calls with concerns when the health center is closed, or if the patient cannot return for an appointment (due to distance or other logistical barriers) we provide them with advice based on their symptoms and, if we feel it is appropriate, we refer them to a nearby hospital. We try to follow up with any patient who calls with these types of concerns to see how they are doing and determine if their symptoms have resolved. If the patient went to a hospital, we seek the patient's permission to contact the hospital to communicate with them about the patient's care and to ensure we have relevant information about the patient's condition. We have never been prevented from communicating with a hospital about a patient because I or any of our other physicians lack admitting privileges to that hospital.

72. In the rare event that a patient needs hospital care (or needs care off-hours, when the health center is closed), patients can obtain such care in hospitals regardless of whether their abortion provider has admitting privileges at that hospital. Hospitals can, and routinely do, communicate with their patients' outside physicians regardless of whether those outside physicians happen to have admitting privileges at that hospital.

73. While I have admitting privileges at a hospital in Tulsa, where I primarily work, I do not have nor do I believe I would be able to obtain such privileges in Oklahoma City or any contiguous county.

74. The other physicians who provide care at CHPPGP's Oklahoma City health center are all out-of-state physicians, none of whom have admitting privileges at a hospital in or near Oklahoma City. Because their primary practice is not in Oklahoma, it is highly unlikely that these out-of-state physicians would be able to obtain admitting privileges at an Oklahoma hospital.

75. I understand the law permits physicians, in lieu of obtaining admitting privileges, to have a contract with another "associated physician" who does have such privileges, but that the

"State Department of Health shall annually submit a copy of the written agreement. . . to each hospital located in the county or a county that is contiguous to the county where the abortion was performed." S.B. 779 § 8(2)(d)(1). There is no medical basis for such a requirement, and I can think of no other area of medicine where a similar requirement is imposed. Indeed, this requirement appears designed to harass both physicians who agree to be associated with abortion providers and the hospitals that are willing to give such associated physicians admitting privileges, as it requires notice sent to all local hospitals, not only the hospital where the physician has privileges.

76. If the Medication Abortion Restrictions went into effect, because none of our physicians have admitting privileges in Oklahoma City or a contiguous county, none of our patients would be able to access medication abortion in our Oklahoma City health center—a health center that provided medication abortion to over 1,000 patients in 2020.

**Conclusion**

77. I have devoted my career to providing high-quality sexual and reproductive health care. I moved to Oklahoma because there was a need for physicians who could provide such care—including, in particular, abortion care. I have come to love the state that is now my home and I care deeply for my patients.

78. The Acts seek to prevent health care providers, including myself, as well as Planned Parenthood Plaintiffs, from advancing our mission to provide high-quality, evidence-based abortion care in a supportive, safe, and non-judgmental environment to those of our patients who choose abortion.

79. The Acts seek to prevent patients from being able to access critical and time-sensitive health care, and from being able to exercise their constitutional right to choose to terminate their pregnancies.

80. If the Challenged Laws go into effect, many of my patients will not be able to easily seek abortion care outside of Oklahoma. Those of my patients with the fewest resources will be the most severely impacted. I fear that many will not be able to obtain safe abortion care at all and will either seek to terminate their pregnancies themselves, outside the medical system, or be forced to carry unwanted pregnancies to term. Many of my patients already face extreme barriers to accessing the care they need, and so those who ultimately would be able to travel out of state would not be able to do so without substantial sacrifices. Those of my patients who are seeking abortion care in the context of intimate partner violence or other family violence will have to risk more than they already do in order to travel out of state to end their unwanted pregnancies.

81. The Challenged Laws come with truly staggering penalties for violations, including criminal sanction (violations are considered "homicide" under the Six Week Ban; under the Medication Abortion Restrictions, unintentional violations constitute misdemeanors and intentional or reckless violations constitute felonies); professional sanction, including suspension or revocation of one's Oklahoma medical license; and mind-boggling financial penalties, including civil liability for punitive damages and attorneys' fees, as well as penalties for violations of S.B. 779's certification requirements of $5,000,000 per violation for medication abortion distributors and $250,000 per violation for physicians.

82. I would not be willing to risk any of these penalties. If the Total Ban, Six Week Ban, OB/GYN Requirement, and the Medication Abortion Restrictions went into effect, no Planned Parenthood physician would risk providing care in violation of those statutes. If the Total Ban went into effect, Planned Parenthood Plaintiffs would be forced to cease providing abortions in Oklahoma. If the Six Week Ban went into effect, we would likely have to turn away the majority of our abortion patients. If the OB/GYN Requirement went into effect, we would have to turn

away even more patients, as four out of five of our doctors, and our only provider in Tulsa (me), would no longer be able to provide abortion care in Oklahoma. If S.B. 779 went into effect, I would no longer be able to provide medication abortion care in Oklahoma City due to the medically unnecessary admitting privileges requirement, and there are no other physicians at Planned Parenthood health centers who could provide medication abortion care there in my stead. If S.B. 778 went into effect, all of our patients would be forced to delay medication abortion due to the medically unnecessary early ultrasound requirement, and at least some patients would be unable to obtain medication abortions in Oklahoma.

83. I know of no other area of medicine where physicians are subjected to criminal penalties, civil liability and professional sanctions for practicing medicine consistent with professional guidelines and evidence-based medicine.

84. Not only will the Challenged Laws prevent people in Oklahoma from being able to control their own reproduction, but they also provide astonishingly few exceptions. The Challenged Laws provide no exceptions for people who are pregnant as a result of rape or incest, or for people who would suffer severe psychological trauma if forced to carry an unwanted pregnancy to term. Indeed, the Six Week Ban explicitly notes that no exceptions to the abortion prohibition exists for patients "based on a claim or diagnosis that the woman will engage in conduct which she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function." H.B. 2441 § 1(A). I find in this language an acknowledgment that people will go to extreme lengths to control their own bodies and their futures; and that depriving them of this ability, as the Challenged Laws seek to do, will lead to severe and irreparable harm to pregnant people in Oklahoma.

Dated: September 1, 2021

Joshua Yap, M.D., MPH, AAHIVS

Sworn before me this 1st
day of September 2021

Felecia Martinez

Notary Public

**IN THE DISTRICT COURT OF OKLAHOMA COUNTY**
**STATE OF OKLAHOMA**

OKLAHOMA CALL FOR REPRODUCTIVE JUSTICE, on behalf of itself and its members; TULSA WOMEN'S REPRODUCTIVE CLINIC, LLC, on behalf of itself, its physicians, its staff, and its patients; ALAN BRAID, M.D., on behalf of himself and his patients; COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, INC., on behalf of itself, its physicians, its staff, and its patients; and PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, on behalf of itself, its physicians, its staff, and its patients,

Plaintiffs,

v.

JOHN O'CONNOR, in his official capacity as Attorney General for the State of Oklahoma; DAVID PRATER, in his official capacity as District Attorney for Oklahoma County; STEVE KUNZWEILER, in his official capacity as District Attorney for Tulsa County; LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; KATIE TEMPLETON, in her official capacity as President of the Oklahoma State Board of Osteopathic Examiners; LANCE FRYE, in his official capacity as the Commissioner of the Oklahoma State Board of Health; and JUSTIN WILSON, in his official capacity as the President of the Oklahoma State Board of Pharmacy; as well as their employees, agents, and successors,

Defendants.

CASE NO._____

**AFFDAVIT OF USHMA UPADHYAY, PH.D., M.P.H. IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY INJUNCTION**

Dr. Ushma Upadhyay declares and states the following:

## Introduction

1. As discussed more below, I am an Associate Professor in Residence, in the Department of Obstetrics & Reproductive Sciences, at the University of California, San Francisco, School of Medicine ("UCSF").

2. I submit this declaration in support of Plaintiffs' Motion for Temporary Injunction against enforcement of Oklahoma HB 1102, HB 2441, HB 1904, SB 778, and SB 779.

3. Based on my personal knowledge, training, and expertise as a researcher who has generated some of the most rigorous and significant research on the safety of abortion and the barriers that women face in obtaining an abortion, it is my opinion that the challenged requirements have no medical justification whatsoever and will only constrain access to an essential healthcare service.

## Professional Credentials and Experience

4. I have been faculty at UCSF since 2009. I am based at Advancing New Standards in Reproductive Health ("ANSIRH"), a program that conducts high-quality and multidisciplinary research on a range of issues related to people's sexual and reproductive lives. I am also Director of Research for the University of California, Global Health Institute's Center of Expertise on Women's Health, Gender, and Empowerment.

5. Prior to my current position and since obtaining my Ph.D., I held various research positions with UCSF, and prior to UCSF, with the New York City Department of Health and Mental Hygiene, Division of Epidemiology. I received a Master of Public Health from the Columbia School of Public Health in 1998 and a Ph.D. from Johns Hopkins School of Public Health in 2006.

6. My research focuses on improving access to high-quality contraception and abortion care and women's empowerment and gender equity in the context of reproductive health. I have expertise in abortion safety, abortion access in the U.S., and medication abortion, among other areas.

7. My training is in epidemiologic and demographic research methods. I use quantitative study designs. I have published over 80 peer-reviewed research papers in a variety of high-quality medical journals, including the Journal of the American Medical Association (JAMA), PLOS Medicine, and the American Journal of Public Health.

8. I have published some of the seminal studies on the safety of abortion, which have demonstrated that abortion is safe and that many laws restricting abortion access lack medical justification. In 2015, I published a paper on abortion safety, based on statistical data from California's Medicaid program, which is considered the best available evidence we have on the safety of abortion today.[1] In 2019, I published an expanded paper using national data.[2] Also, in 2018, I published a retrospective case series investigating the effects of admitting privileges

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[1] Ushma D. Upadhyay, et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125(1) Obstetrics & Gynecology 175-83 (2015) [*hereinafter*, "2015 ED Study"], *available at* https://journals.lww.com/greenjournal/Fulltext/2015/01000/Incidence_of_Emergency_Department_Visits_and.29.aspx.

[2] Ushma D. Upadhyay, et al., *Abortion-Related Emergency Department Visits in the United States: An Analysis of a National Emergency Department Sample*, 16(88) BMC Med. 1-11 (2018) [*hereinafter*, "2018 National ED Study"], *available at* https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-018-1072-0.

requirements for abortion providers, finding that admitting privileges requirements do not improve patient safety.[3]

9. I have been invited to give lectures and presentations on topics related to reproductive health, including abortion safety, by organizations, such as the North American Forum on Family Planning, the Annual Meeting of the Population Association of America, and the American Public Health Association, and universities, such as the University of California, Los Angeles, Emory University, and Brown University.

10. A copy of my curriculum vitae with a complete listing of my professional background, experience, and publications is attached hereto as Exhibit A.

**Abortion Care in the United States**

11. There are generally two methods of abortion—medication and procedural.

12. The most common form of medication abortion is a regimen of two prescription medications, mifepristone and misoprostol. Mifepristone, also known by its commercial name Mifeprex, was first approved by the U.S. Food and Drug Administration (FDA) in 2000 as an effective alternative to procedural abortion in early pregnancy when used in conjunction with misoprostol. The FDA has confirmed that this protocol is extremely safe and effective in terminating pregnancy.

13. Procedural abortion involves the use of instruments and/or medications to gently dilate (open) the cervix and remove the contents of the uterus. It is almost always performed in an outpatient setting and involves local anesthesia and sometimes conscious sedation.

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[3] Ushma D. Upadhyay, et al., *Admitting Privileges and Hospital-Based Care After Presenting for Abortion: A Retrospective Case Series*, 54(2) Health Serv. Rsch. 425-36 (2018/2019), *available at* https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.13080.

14. A wide array of providers perform abortion care, including physicians of different specialties such as emergency medicine, family medicine, and obstetrics and gynecology (OB/GYN). First trimester procedural and medication abortions can also be safely performed by advanced practice clinicians (APCs), such as nurse practitioners.

**The Challenged Laws**

15. I understand that H.B. 1102 bans abortion entirely by declaring that providing abortion constitutes unprofessional conduct such that physicians who provide abortions are subject to, at a minimum, suspension of licensure for one year. I further understand that H.B. 2441 bans abortion at approximately six weeks in pregnancy, making the provision of an abortion in violation of the act a homicide.

16. I understand that H.B. 1904 will dramatically reduce the number of abortion providers in the state without any medical justification by barring highly skilled and competent physicians, including family medicine doctors, from providing abortions because they are not board-certified OB/GYNs.

17. I understand that S.B. 778 imposes medically unjustified and burdensome requirements solely for doctors providing medication abortion. For example, I understand it requires patients to get an ultrasound 72 hours in advance of obtaining a medication abortion, which is medically unnecessary and irrelevant to the safe and effective provision of medication abortion.

18. I understand that S.B. 779 requires various agencies to impose an extensive certification system for manufacturers, distributors, and providers of medication abortion. Components of this scheme include requiring physicians to have admitting privileges at a local

hospital or a contract with a physician who does and limiting the accessibility of medication abortion to 10 weeks from a patient's last menstrual period ("LMP").

**Abortion Care is Extraordinarily Safe**

19. Abortion is one of the most studied procedures in outpatient medicine. It is extremely safe with a low rate of complications. A recent, robust analysis of the full spectrum of abortion care in the U.S. performed by the National Academies of Sciences, Engineering, and Medicine, a national entity that brings together diverse perspectives to examine public health issues, concluded that abortion continues to be one of safest, most common medical procedures performed in the nation.[4] Serious complications are exceedingly rare; "in the vast majority of studies, they occur in fewer than 1 percent of abortions."[5]

20. My robust research on abortion safety was cited in the National Academies' findings on the issue. In my team's study of a nationally representative sample of emergency department visits, encompassing nearly 200 million weighted emergency department visits, abortion-related visits represented 0.01% of visits among women of reproductive age.[6] Half of the abortion-related visits received only observation, which did not require any treatment at all.[7]

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[4] National Academies of Science, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States*, 2018, *available at* http://nap.edu/24950 [*hereinafter*, "NAS, Safety and Quality of Abortion Care"]; *id.* at 77 ("The clinical evidence makes clear that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective.").

[5] *Id.*

[6] 2018 National ED Study at 5, 7.

[7] *Id.* at 6.

Serious complications, requiring blood transfusion, surgery, or an overnight stay accounted for 20.3% of the 0.01% of visits—that is 0.002% of all emergency department visits.[8]

21. The major incident rate for abortion is lower than published rates for pregnancy, as well as for other common procedures, such as colonoscopy, wisdom tooth removal, and tonsillectomy.[9]

22. The vast majority of abortions are performed in an office or clinic setting.[10] Indeed, my 2015 study found that 97% of abortions in our sample occurred at outpatient facilities.[11]

23. The research also shows that a wide array of providers can safely perform abortion care. For example, my team conducted a study that shows that APCs can provide first trimester procedural abortions as safely as physicians.[12]

24. There is no medical or scientific reason to restrict abortion provision only to OB/GYNs, given that a wide variety of clinicians can receive training in abortion care and go on to provide safe and effective abortion care.

25. There is no evidence or other reason to believe that OB/GYNs provide care more safely than either family medicine physicians or APCs.

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[8] *Id.* at 7.

[9] *Id.* at 8; NAS, Safety and Quality of Abortion Care, at 75-76.

[10] Sarah C. M. Roberts, et al., *Association of Facility Type with Procedural-Related Morbidities and Adverse Events Among Patients Undergoing Induced Abortions*, 319(24) JAMA 2497-2506 (2018), available at https://jamanetwork.com/journals/jama/fullarticle/2685987.

[11] 2015 ED Study at 177.

[12] Tracy A. Weitz, et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants under a California Legal Waiver*, 103(3) Am. J. Pub. Health 454-61 (2013), *available at* https://ajph.aphapublications.org/doi/10.2105/AJPH.2012.301159.

26. Indeed, according to the Academies, "[t]he clinical evidence presented . . . on the provision of safe and high-quality abortion care stands in contrast to the extensive regulatory requirements that state laws impose on the provision of abortion services."[13]

**Medication Abortion**

27. Medication Abortion is one of the safest medication regimens in medicine today.[14] My 2015 study found that less than one third of 1 percent of medication abortions resulted in a serious complication.[15]

28. Research consistently shows that medication abortion is safer than many other common medications, including antibiotics and over-the-counter drugs, such as Advil or Tylenol.[16]

29. Given the robust evidence of the safety of medication abortion, medicine is moving away from medically unnecessary restrictions on access to the regimen.[17] For example, the FDA is currently reconsidering the mifepristone Risk Evaluation and Mitigation Strategy ("REMS"), which sets forth certain restrictions on the provision of the medication.[18] In 2016, the FDA dropped

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[13] NAS, Safety and Quality of Abortion Care, at 77.

[14] ANSIRH, *Analysis of Medication Abortion Risk and the FDA Report "Mifepristone U.S. Post-Marketing Adverse Events Summary through 12/31/2018"*, Issue Brief (Apr. 2019), *available at* https://www.ansirh.org/sites/default/files/publications/files/mifepristone_safety_4-23-2019.pdf.

[15] 2015 ED Study at 181.

[16] NAS, Safety and Quality of Abortion Care, at 58, 79; *see also* source cited *supra* at n.14.

[17] Ushma D. Upadhyay, et. al, *Safety and Efficacy of Telehealth Medication Abortions in the US During the COVID-19 Pandemic*, 4(8) JAMA Network Open 1-3 (2021), *available at* https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2783451.

[18] American Civil Liberties Union, *Press Release: FDA Announces Long Sought-After Review of Harmful Restrictions on Medication Abortion* (May 7, 2021), *available at*

a requirement for in-person follow up visits for medication abortion patients based on mounting evidence that the requirement was not medically necessary.[19] In 2016, the FDA also updated the mifepristone label to match the evidence-based practice at the time to provide the medication abortion regimen up to 10 weeks LMP.[20] Evidence now supports the use of the regimen up to 11 weeks LMP.[21]

30. Evidence shows that provision of medication abortion without pre-abortion ultrasound or other tests can also be safe and effective.[22]

31. During the COVID pandemic, some abortion providers sought to provide medication abortion with reduced physical contact, to reduce the risk of viral COVID transmission. Evidence has shown that this care has proven safe and effective.[23]

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https://www.aclu.org/press-releases/fda-announces-long-sought-after-review-harmful-restrictions-medication-abortion.

[19] FDA, *Questions and Answers on Mifeprex*, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifeprex, *accessed* August 9, 2021; Wesley Clark, et al., *Alternatives to a Routine Follow-Up Visit for Early Medical Abortion*, 115(2 pt. 1) Obstetrics & Gynecology 264-72 (2010), *available at* https://journals.lww.com/greenjournal/Fulltext/2010/02000/Alternatives_to_a_Routine_Follow_Up_Visit_for.10.aspx.

[20] *See* source cited *supra* at n.14.

[21] National Abortion Federation, *2020 Clinical Policy Guidelines for Abortion Care*, at 16-17, *available at* https://5aa1b2xfmfh2e2mk03kk8rsx-wpengine.netdna-ssl.com/wp-content/uploads/2020_CPGs.pdf.

[22] *See* source cited *supra* at n.17.

[23] *Id.*; Erica Chong, et al., *Expansion of a Direct-to-Patient Telemedicine Abortion Service in the United States and Experience during the COVID-19 Pandemic*, 104(1) Contraception 43-48 (2021), *available at* https://www.sciencedirect.com/science/article/abs/pii/S0010782421000913; Ushma D. Upadhyay, et al., *Adoption of No-Test and Telehealth Medication Abortion Care among Independent Abortion Providers in Response to COVID-19*, 2 Contraception X 100049 (2020), *available at* https://pubmed.ncbi.nlm.nih.gov/33305255/.

32. There is no medical reason to subject medication abortion to the kinds of specialized, onerous schemes enacted in S.B. 778 or S.B. 779. The requirements of these schemes are irrelevant to the safety or efficacy of medication abortion.

33. Mandating that an ultrasound be conducted at least 72 hours in advance of a medication abortion provides no medical benefit and only serves to restrict access to care. I understand that Plaintiffs already conduct ultrasounds for abortion patients on the day of their abortion. Requiring that the ultrasound be conducted days earlier, and requiring patients to make two medical appointments at least three days apart, provides no medical benefit whatsoever.

34. Specialized provider qualifications like those in these bills, including the admitting privileges requirement, are also medically irrelevant to patient care. As previously noted, I have authored an article concerning admitting privileges requirements for abortion care. We looked at data from abortion providing facilities before and after laws went into effect requiring admitting privileges for abortion providers. While the incidence of hospital referral was rare, as would be expected, the data we reviewed showed no difference in patient care or the means by which patients obtained hospital-based care after admitting privileges requirements went into effect, nor did we find any increased coordination between abortion providers and hospitals after admitting privileges requirements went into effect.[24]

35. The myriad requirements related to reporting complications that I understand are part of S.B. 778 and 779 are also untethered to the safe or effective provision of medication abortion. Medication abortion is safe and effective, and there is no medical reason to subject it to unique and burdensome regulation.

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[24] *See* source cited *supra* at n.3.

## Access to Abortion is Essential for Women's Health

36. Although the U.S. abortion rate has declined, abortion is still a common and necessary procedure—1 in 4 American women will obtain an abortion in their lifetime.[25]

37. Abortion is increasingly concentrated among poor and low-income women who live at or below 100-200% of the federal poverty level and who accounted for 75% of abortion patients in 2014.[26]

38. Abortion is a time-sensitive medical service, but patients often face significant delays in accessing care due to barriers imposed by state law restrictions,[27] which increase the amount of travel and/or impose other logistical barriers. Research consistently shows that access to abortion care is very sensitive to increases in logistical burdens—even small increases in travel distance or congestion at abortion facilities due to reduced access can stop patients from getting care and force them to carry an unwanted pregnancy to term.[28]

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[25] Guttmacher Institute, *Abortion is a Common Experience for U.S. Women, Despite Dramatic Declines in Rates* (Oct. 19, 2017), *available at* https://www.guttmacher.org/news-release/2017/abortion-common-experience-us-women-despite-dramatic-declines-rates.

[26] *Id.*

[27] Jason M. Lindo & Mayra Pineda-Torres, *New Evidence on the Effects of Mandatory Waiting Periods for Abortion*, Working Paper No. 26228, Nat'l Bureau of Econ. Rsch. (June 2021), *available at* http://people.tamu.edu/~jlindo/MandatoryWaitingPeriods_LindoPinedaTorres.pdf.

[28] Caitlin Myers, *Cooling off or Burdened? The Effects of Mandatory Waiting Periods on Abortions and Births*, IZA D.P. No. 14434, IZA Inst. of Labor Econ. (June 2021), *available at* http://ftp.iza.org/dp14434.pdf; Daniel Grossman, *The Use of Public Health Evidence in Whole Woman's Health v Hellerstedt*, 177(2) JAMA Intern Med. 155-156 (2017), *available at* https://pubmed.ncbi.nlm.nih.gov/27820613/; Jason M. Lindo, et al., *How Far Is Too Far? New Evidence on Abortion Clinic Closures, Access, and Abortions*, 55(4) J. Hum. Res. 1137-60, Univ. of Wis. Press (2020), *available at* http://jhr.uwpress.org/content/early/2019/05/01/jhr.55.4.1217-9254R3.abstract; Troy Quast, et al., *Abortion Facility Closings and Abortion Rates in Texas*, 54 Inquiry 1-7 (2017), *available at* https://pubmed.ncbi.nlm.nih.gov/28351188/; Stefanie Fischer, et al., *The Impacts of Reduced Access to Abortion and Family Planning Services on Abortions, Births, and Contraceptive Purchases*, 167 J. Pub. Econ. 43-68 (2018), *available at*

39. Many states, including Oklahoma, already have limited access to care. A paper on which I was a senior author showed that in 2017, there were only 4 publicly advertising abortion clinics in Oklahoma, corresponding to 220,527 women of reproductive age per facility.[29] I understand that today, there are the same number of clinics, which are concentrated in two metropolitan areas. Thus, patients already must travel very long distances to reach an abortion provider. Patients who live in rural areas often must travel 50 to 100 miles, and in some cases 200 miles or more, to obtain abortion care.[30] Having to travel long distances and expend resources is associated with delays in obtaining care, different types of care, increased costs, and stress.[31] In my team's national study of people denied an abortion, travel and procedure costs were the most

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https://www.sciencedirect.com/science/article/abs/pii/S0047272718301531; Joanna Venator & Jason Fletcher, *Undue Burden Beyond Texas: An Analysis of Abortion Clinic Closures, Births, and Abortions in Wisconsin*, 40(3) J. Policy Analysis & Mgmt. 774-813 (2021), *available at* https://onlinelibrary.wiley.com/doi/10.1002/pam.22263.

[29] Alice F. Cartwright, et al., *Identifying National Availability of Abortion Care and Distance from Major US Cities: Systematic Online* Search, 20(5) J. Med. Internet Rsch. e186 (2018), *available at* https://pubmed.ncbi.nlm.nih.gov/29759954/.

[30] Liza Fuentes & Jenna Jerman, *Distance Traveled to Obtain Clinical Abortion Care in the United States and Reasons for Clinic Choice*, 28(12) J. Women's Health 1623-31 (2018), *available at* https://pubmed.ncbi.nlm.nih.gov/31282804/; Jonathon Bearak, et al., *Disparities and Change over Time in Distance Women Would Need to Travel to have an Abortion in the USA: A a Spatial Analysis*, 2(11) Lancet Pub. Health 493-500 (2017), *available at* https://pubmed.ncbi.nlm.nih.gov/29253373/; Caitlin Myers, et al., *Predicted Changes in Abortion Access and Incidence in a Post-Roe World*, 100(5) Contraception 367-73 (2019), *available at* https://pubmed.ncbi.nlm.nih.gov/31376381/.

[31] Mickey Sperlich, et al., *Reflections of Stress in US Abortion Narratives*, 20(5) J. Soc. Work 533-56 (2020), *available at* https://journals.sagepub.com/doi/abs/10.1177/1468017319852602; Caitlin Gerdts, et al., *Impact of Clinic Closures on Women Obtaining Abortion Services after Implementation of a Restrictive Law in Texas*, 106(5) Am. J. Public Health 857-64 (2016), *available at* http://sites.utexas.edu/txpep/files/2017/04/Gerdts-Impact-of-Clinic-Closures-AJPH-pre-print-2016.pdf; Jill Barr-Walker, et al., *Experiences of Women Who Travel For Abortion: A Mixed Methods Systematic Review*, 14(4) PloS One (2019), *available at* https://pubmed.ncbi.nlm.nih.gov/30964860/.

common reason for delay in reaching care.[32] Low-income people in particular experience these barriers, including difficulties taking time off work to seek care (and therefore foregoing needed income), finding childcare, and paying for gas or other transportation costs.[33]

40. Although remaining a straightforward procedure, abortion becomes more complex and expensive as pregnancy advances—delays in accessing care can prevent some people from being able to choose a medication abortion, even if that would have been the right choice for them; push people from an earlier to a later procedure; and/or push people from a one-day to a two-day procedure.[34] Delays can also push patients beyond the time during which they may obtain an abortion at all.[35]

41. Although abortion remains safe, risk can increase if patients are forced to receive later procedures.[36] People with certain medical conditions may experience worsening health with advancing pregnancy, such as people with hypertension.[37]

42. Research shows that patients denied access to a wanted abortion experience worse outcomes than patients who were able to receive abortion care.

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[32] Ushma Upadhyay, et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104(9) Am. J. Pub. Health 1687-94 (2014), *available at* https://pubmed.ncbi.nlm.nih.gov/23948000/.

[33] *See* sources cited *supra* at nn.27-28.

[34] *Id.*

[35] *Id.*

[36] 2018 National ED Study at 5, 7.

[37] Elizabeth Raymond & David Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2 pt. 1) Obstetrics & Gynecology 215-19 (2012), *available at* https://pubmed.ncbi.nlm.nih.gov/22270271/; 2018 National ED Study at 92, 94.

43. Employing data from the Turnaway Study,[38] researchers confirmed that carrying an unwanted pregnancy to term is far riskier to women's physical health than having an abortion. In the short term, women giving birth after being denied an abortion experience more potentially life-threatening complications, such as preeclampsia and postpartum hemorrhage, than those who were able to obtain an abortion.[39] Over five years, women who give birth after being denied an abortion report more chronic pain and rate their overall health as worse, than women who were able to obtain an abortion.[40]

44. Researchers also found that women who were denied an abortion were more likely to experience economic hardship and financial insecurity than women who obtained a wanted abortion. Women were more likely to live in poverty for four years after being denied an

[38] The Turnaway Study is a longitudinal study by researchers at UCSF/ANSIRH examining the effects of unintended pregnancy on women's lives. I was a member of the group of researchers who published papers as part of the Turnaway Study. The study followed about a thousand women who sought abortions at 30 facilities across the country, some of whom obtained an abortion and some of whom were denied an abortion due to gestational limits. Participants were interviewed several times over a five-year period on topics including physical and mental health, employment and educational attainment, relationship status, contraceptive use, emotions about pregnancy and abortion, and other related topics. In all, researchers conducted almost 8,000 interviews for the project. Researchers also gathered information on the women's children—those the women had prior and subsequent to the obtained or denied abortion, and those resulting from the unintended pregnancy.

[39] Caitlin Gerdts, et al., *Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth After an Unwanted Pregnancy*, 261(1) Women's Health Issues 55-59 (2016), *available at* https://www.ibisreproductivehealth.org/publications/side-effects-physical-health-consequences-and-mortality-associated-abortion-and-birth.

[40] Lauren J. Ralph, et al., *Self-Reported Physical Health of Women Who Did and Did Not Terminate Pregnancy After Seeking Abortion Services: A Cohort Study*, 171(4) Annals of Internal Med., 238-47 (2019), *available at* https://ucdavis.pure.elsevier.com/en/publications/self-reported-physical-health-of-women-who-did-and-did-not-termin.

abortion.[41] Women who were denied an abortion had lower levels of employment for the first four years of the study[42] and were more likely to report not having "enough money to pay for basic living expenses like food, housing, and transportation" than those who obtained an abortion. [43]

45. I was the lead author and a co-author on studies based on this data that examined women's one-year[44] and five-year plans for their own lives.[45] These plans included child-related plans, financial plans, educational plans, and relationship plans.[46] This research showed that women who received an abortion were much more likely than women who were denied a wanted abortion to set aspirational plans.[47]

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[41] Diana Greene Foster, et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108(3) Am. J. Pub. Health 407-13 (2018), *available at* https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304247; *see also* Diana Greene Foster, *The Turnaway Study: Ten Years, a Thousand Women, and the Consequences of Having—or Being Denied—an Abortion* at 176 (2020) [*hereinafter*, "The Turnaway Study: Ten Years"] ("Six months after our study participants either terminated their pregnancies or gave birth, 61% of those who were turned away were living below the poverty level, compared to 45% who received the abortion . . . They [also] remain significantly more likely to be poor for the next four years").

[42] The Turnaway Study: Ten Years at 175 ("It took four years for women who were turned away and gave birth to catch up to the level of employment experienced by women just under the limit who received their abortion. Those years of either steady or unstable employment can have significant impact on women's and their families' economic well-being.").

[43] *Id.* at 175, 202.

[44] Ushma D. Upadhyay, et al., *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15(102) BMC Women's Health 1-10 (2015), *available at* https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-015-0259-1.

[45] Molly A. McCarthy, et al., *The Effect of Receiving Versus Being Denied an Abortion on Making and Achieving Aspirational 5-Year Life Plans*, 46(3) BMJ Sexual & Reproductive Health 177-83 (2020), *available at* https://srh.bmj.com/content/46/3/177.abstract.

[46] *See* sources cited supra at nn.44-45.

[47] *Id.*

46. Although abortion is not associated with any mental health harms, women denied abortions experience stress around being denied care.[48]

47. Women who are unable to access abortion also may be at increased risk of continued violence from intimate partners.[49]

48. The Turnaway Study also demonstrated that when women are denied abortions, their existing families suffer. Researchers found measurable differences in the economic wellbeing and development of existing children as compared to those whose mothers were denied a wanted abortion. Conversely, children born later to women who were able to get an abortion experienced more economic security and better maternal bonding than the children born because a woman was denied an abortion.[50]

49. Abortion is a common, safe, and effective medical procedure, whether provided by medication or procedure. It is also vital for people who seek it in determining the course of their lives and in forming their families. Delaying and denying access to this care, as the challenged laws will do, hurts patients and their families, including their current and future children.

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[48] Laura F. Harris, et al., *Perceived Stress and Emotional Social Support Among Women Who Are Denied or Receive Abortions in the United States: A Prospective Cohort Study*, 14(76) BMC Med. 1-11 (2014), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4080695/.

[49] Sarah C. M. Roberts, et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12(144) BMC Med. 1-7 (2014), *available at* https://pubmed.ncbi.nlm.nih.gov/25262880/.

[50] Diana Greene 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(11) JAMA Pediatrics 1053-60 (2018), *available at* https://pubmed.ncbi.nlm.nih.gov/30193363/; Diana Greene Foster, et al., *Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children*, 205 J. Pediatrics, 183-89 (2018), *available at* https://pubmed.ncbi.nlm.nih.gov/30389101/.

50. I am unaware of any other area of medicine where a healthcare provider can face severe criminal and licensing penalties, such as a homicide charges, for providing safe and effective medical care in accordance with FDA requirements and the guidance of leading medical organizations.

DATED:
8/31/21

Ushma Upadhyay, Ph.D., M.P.H.

NOTARY

Please see attached.

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Contra Costa

Subscribed and sworn to (or affirmed) before me on this 31st day of August, 2021, by Margaret Allensworth Fohl, Notary Public,
proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

MARGARET ALLENSWORTH FOHL
Notary Public - California
Contra Costa County
Commission # 2308297
My Comm. Expires Oct 10, 2023

(Seal)

Signature

# EXHIBIT A

Prepared: June 9, 2021

**University of California, San Francisco**

# CURRICULUM VITAE


**Name:** Ushma D. Upadhyay, PhD, MPH

**Position:** Associate Professor In Residence, Step 3
Obstetrics, Gynecology & Reproductive Sciences
School of Medicine

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Web: http://www.ansirh.org/staff-members/ushma-upadhyay


## EDUCATION

| | | | | |
|---|---|---|---|---|
| 1991 - 1995 | The American University Washington, DC | BA | Public Communication & International Studies | |
| 1993 - 1993 | Universidad Mayor de San Simon Cochabamba, Bolivia | | Sustainable Development | |
| 1996 - 1998 | Columbia School of Public Health New York, NY | MPH | Population & Family Health | |
| 2000 - 2006 | Johns Hopkins Bloomberg School of Public Health Baltimore, MD | PhD | Reproductive, Perinatal & Women's Health | Advisor: Michelle J Hindin, PhD |

## LICENSES, CERTIFICATION

2006 Johns Hopkins University Research Coordinator Training Program, Baltimore, MD

## PRINCIPAL POSITIONS HELD

| | | | |
|---|---|---|---|
| 1996 - 1997 | Columbia-Presbyterian Hospital, New York, NY | Clinic Counselor | Family Planning Clinic |
| 1997 - 1998 | New York State Department of Health, New York, NY | Research Assistant | Maternal and Child Health Bureau |
| 1998 - 1999 | Johns Hopkins Bloomberg School of Public Health, Baltimore, MD | Research Analyst | Center for Communication Programs |

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|---|---|---|---|
| 1999 - 2005 | Johns Hopkins Bloomberg School of Public Health, Baltimore, MD | Technical Writer | Center for Communication Programs |
| 2005 - 2007 | Johns Hopkins Bloomberg School of Public Health, Baltimore, MD | Associate Editor | Center for Communication Programs |
| 2007 - 2008 | New York City Department of Health and Mental Hygiene, New York | Postdoctoral Research Scientist | Division of Epidemiology |
| 2009 - 2009 | University of California, San Francisco, CA | Specialist, Step II | Dept. of Ob, Gyn & Reproductive Sci. |
| 2009 - 2011 | University of California, San Francisco, CA | Assistant Research Scientist, Step III | Dept. of Ob, Gyn & Reproductive Sci. |
| 2011 - 2013 | University of California, San Francisco, CA | Assistant Research Scientist, Step IV | Dept. of Ob, Gyn & Reproductive Sci. |
| 2013 - 2016 | University of California, San Francisco, CA | Assistant Adjunct Professor, Step III | Dept. of Ob, Gyn & Reproductive Sci. |
| 2016 - present | University of California, San Francisco, CA | Associate Professor in Residence, Step I | Dept. of Ob, Gyn & Reproductive Sci. |
| 2018 - present | University of California, San Francisco, CA | Associate Professor in Residence, Step II | Dept. of Ob, Gyn & Reproductive Sci. |

## OTHER POSITIONS HELD CONCURRENTLY

| | | | |
|---|---|---|---|
| 2008 - 2010 | New York City Department of Health and Mental Hygiene, New York | Consultant | Division of Epidemiology |
| 2009 - 2009 | IFC Macro International, Calverton, MD | Fellow | Demographic and Health Surveys |
| 2010 - 2011 | UC Center of Expertise on Women's Health and Empowerment, San Francisco, CA | Postdoctoral Fellow | UC Global Health Institute |

## HONORS AND AWARDS

| | | |
|---|---|---|
| 1991 | Cum Laude, Dean's List | American University |

| | | |
|---|---|---|
| 1997 | Graduate Research Assistantship | Columbia University |
| 2005 | Endowed Fellowship in Family Planning and Reproductive Health | Johns Hopkins Bloomberg School of Public Health |
| 2007 | New Investigator in Global Health Award | Global Health Council |
| 2011 | Best Research Poster | National Abortion Federation |
| 2013 | Outstanding Researcher Award | Society of Family Planning |
| 2015 | Best Research Poster | National Abortion Federation |
| 2017 | Best Oral Abstract | National Abortion Federation |
| 2021 | Psychosocial Workshop | Most Engagement Award |

### KEYWORDS/AREAS OF INTEREST

Sexual and reproductive health, women's empowerment, women's reproductive autonomy, relationship power, gender-based power, access to contraception, contraceptive technology, medical barriers to contraceptive provision, international family planning programs, abortion restrictions, abortion procedures, complications of abortion, medication abortion, adolescent sexual behavior, South Asian American health.

## PROFESSIONAL ACTIVITIES

### MEMBERSHIPS

| | |
|---|---|
| 1997 - present | South Asian Women's Network, Member |
| 1999 - present | South Asian Public Health Association, Member |
| 2003 - present | Population Association of America, Member |
| 2009 - present | Society of Family Planning, Fellow |

### SERVICE TO PROFESSIONAL ORGANIZATIONS

| | | |
|---|---|---|
| 1999 - 2004 | South Asian Public Health Association | Founding Board Member |
| 2005 - 2012 | American Public Health Association | Abstract Reviewer |
| 2005 - 2012 | South Asian Women's Network (sawnet.org) | Moderator |
| 2021 - 2021 | California Abortion Alliance | Board Member |

### SERVICE TO PROFESSIONAL PUBLICATIONS

| | |
|---|---|
| 2007 - 2007 | Feminist Economics Ad hoc referee |
| 2007 - 2010 | AIDS Care Ad hoc referee |
| 2010 - 2010 | Economics and Human Biology Ad hoc referee |
| 2008 - 2011 | Journal of Adolescence Ad hoc referee |

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|---|---|
| 2009 - 2011 | Asia-Pacific Journal of Public Health Ad hoc referee |
| 2011 - 2011 | BMC Health Services Research Ad hoc referee |
| 2011 - 2011 | Demography Ad hoc referee |
| 2012 - 2012 | Stigma Research and Action Ad hoc referee |
| 2012 - 2013 | Culture, Health and Sexuality Ad hoc referee |
| 2006 - present | Journal of Adolescent Health Ad hoc referee |
| 2007 - present | Studies in Family Planning Ad hoc referee |
| 2010 - present | International Perspectives in Reproductive and Sexual Health Ad hoc referee |
| 2012 - present | Contraception Ad hoc referee |
| 2014 - present | Journal of Immigrant and Minority Health Ad hoc referee |
| 2015 - present | Archives of Sexual Behavior Ad hoc referee |
| 2017 - present | The Journal of Sex Research Ad hoc referee |

## INVITED PRESENTATIONS - INTERNATIONAL

| | | |
|---|---|---|
| 2005 | World Health Organization Family Planning Technical Meeting, Geneva, Switzerland | Presenter |

## INVITED PRESENTATIONS - NATIONAL

| | | |
|---|---|---|
| 2005 | Reproductive Health Materials Working Group, Washington, DC | Presenter |
| 2011 | Public Health Institute, International Women's Day | Web Lecturer |
| 2012 | Mifepristone Medical Abortion Meeting, New York City | Presenter |
| 2014 | National Abortion Federation Regional Meeting, Cleveland, OH | Presenter |
| 2015 | Bridging the Divide Medication Abortion Roundtable, Washington, DC | Presenter |
| 2016 | Population Association of America, Washington, DC | Discussant |
| 2016 | Population Association of America, Washington, DC | Session Chair |
| 2017 | Population Association of America, Chicago, IL | Discussant |
| 2017 | Population Association of America, Chicago, IL | Session Chair |
| 2017 | Society of Family Planning, Atlanta, GA | Moderator |
| 2018 | Population Association of America, Denver, CO | Session Chair |
| 2018 | North American Forum on Family Planning, New Orleans, LA | Presenter & Planner |

| | | |
|---|---|---|
| 2019 | Abortion Care Network Annual Conference, Las Vegas, NV | Presenter |
| 2019 | Society of Family Planning, Los Angeles, CA | Presenter & Moderator |
| 2020 | Abortion Care Network, Louisville, KY | Presenter |
| 2020 | Center for Reproductive Rights Webinar | Presenter |
| 2020 | Abortion Care Network Webinar | Presenter |
| 2020 | National Abortion Federation | Presenter |
| 2020 | Mavericks Webinar | Presenter |
| 2020 | Society of Family Planning | Presenter |
| 2020 | Gynuity Annual Mifepristone Meeting | Presenter |
| 2020 | PPFA 6th Annual TeleMAB Stakeholders | Presenter |
| 2020 | NASEM Virtual Workshop on Family Planning, Women's Empowerment, And Population And Societal Impacts | Presenter |
| 2020 | Society of Family Planning, Online | Presenter |
| 2021 | Population Association of America, Online | Session Chair |
| 2021 | Population Association of America, Online | Session Chair |
| 2021 | National Abortion Federation | Presenter |

**INVITED PRESENTATIONS - REGIONAL AND OTHER INVITED PRESENTATIONS**

| | | |
|---|---|---|
| 2019 | UCSF Bixby Abortion Seminar | Presenter |
| 2020 | UC Berkeley | Guest Lecturer |
| 2020 | ICAN Meeting on Self-Injection of DMPA-SC in Sub-Saharan Africa | Presenter |
| 2020 | UCLA Bixby Center on Population and Reproductive Health | Presenter |
| 2020 | ANSIRH Brown Bag | Presenter |
| 2020 | UCGHI Student Ambassadors Webinar | Presenter |
| 2020 | ANSIRH Brown Bag | Presenter |
| 2020 | WHGE COE Virtual Retreat | Presenter |
| 2020 | California Coalition for Reproductive Freedom (CCRF) | Presenter |
| 2020 | Bixby Center Virtual Webinar Series | Presenter |
| 2020 | California Abortion Alliance Webinar | Presenter |

# UNIVERSITY AND PUBLIC SERVICE

## SERVICE ACTIVITIES SUMMARY

I have served in a leadership capacity within the UC System for over 5 years. Since 2016 I have been Director of Research of the UC Global Health Initiative (UCGHI) Center of Expertise in Women's Health, Gender, and Empowerment. Since 2020, I have also served on UCGHI's Black Lives Matter Taskforce. UCGHI is a 10-campus UC-wide initiative that stimulates, nurtures, and promotes global health research, education, and collaboration to advance the University's global health agenda.

My service activities to UCSF: Since 2012 I have served on UCSF RAP Review Committees. First I was on the mHealth Committee for 2 years and then in 2014 I joined the Career Development Review Committee, on which I still serve. This commitment involves serving on review committees, reviewing up to 3 grant proposals for 2 cycles/year.

## UNIVERSITY SERVICE

### UC SYSTEM AND MULTI-CAMPUS SERVICE

| | | |
|---|---|---|
| 2010 - 2016 | UC Global Health Initiative Center of Expertise in Women's Health and Empowerment | Member, Research Committee |
| 2015 - 2016 | UC Global Health Initiative Center of Expertise in Women's Health and Empowerment | Co-Chair, Knowledge Dissemination Committee |
| 2016 - present | UC Global Health Initiative Center of Expertise in Women's Health, Gender, and Empowerment | Director of Research |

### UCSF CAMPUSWIDE

| | | |
|---|---|---|
| 2012 - 2014 | RAP mHealth Review Committee | Grant proposal reviewer |
| 2014 - present | RAP Career Development Review Committee | Grant proposal reviewer |
| 2016 - 2016 | Parent Network Work Group | Work group member |

### SCHOOL OF MEDICINE

-

### DEPARTMENTAL SERVICE

| | | |
|---|---|---|
| 2013 - 2013 | Department of Obstetrics, Gynecology, & Reproductive Sciences, Research Retreat Committee | Member |
| 2018 - present | Bixby Membership Committee | Member |
| 2020 - 2020 | BIRCWH K Award Proposal Reviewer | Reviewer |

## COMMUNITY AND PUBLIC SERVICE

| | | |
|---|---|---|
| 1997 - 1998 | SAKHI for South Asian Women, New York, NY (intimate partner violence organization) | Volunteer |
| 2009 - 2009 | MedShare International, San Francisco, CA | Volunteer |
| 2005 - 2012 | South Asian Women's Network (sawnet.org) | Moderator |
| 2011 - 2014 | Golden Gate Mothers Group, San Francisco, CA | Volunteer, Web Team |
| 2015 - 2016 | Golden Gate Mothers Group, San Francisco, CA | Chair, Web Team |
| 2018 - 2019 | Society of Family Planning, Denver, CO | Changemakers Ambassador |

# CONTRIBUTIONS TO DIVERSITY

## CONTRIBUTIONS TO DIVERSITY

I am passionate about doing anti-racist work that I hope will improve equity within academia. Towards this end, I serve on the following UCSF committees:
1) In June 2020 I joined the University of California Global Health Institute's Black Lives Matters Taskforce (https://ucghi.universityofcalifornia.edu/ucghi-black-lives-matter-task-force). The Taskforce meets weekly and has developed an extensive work plan of activities that we will carry out over the coming year.
2) In 2019 I served on ANSIRH's DEI Faculty Hiring Group which led to the hiring of a faculty member this year in 2021.
3) I have also been working on an ANSIRH committee to develop a guidance document on Anti-Racist Practices for Academic Work. I currently also serve on a UCSF RAP grant review committee for underrepresented faculty in medicine.

I am committed to supporting the development of reproductive health scholars of color. I serve on the Society of Family Planning's Change Maker review committee, a dedicated effort is needed to actively support scholars of color focused on abortion and contraception. In this role, I help to identify and award grants to scholars of color who are beginning their academic careers in the field. Additionally, through individual mentoring, I have made substantial contributions to supporting diversity among the reproductive health academic community. I mentor several undergraduate and graduate students, most of whom identify as BIPOC. I bring a unique perspective to the mentoring relationship. I encourage and support the special needs and interests of women investigators who may face a variety of institutional and structural barriers.

As a woman of South Asian descent myself, who was raised primarily by a single mother who immigrated from Tanzania, I am drawn to reproductive autonomy, health, and well-being from a social justice perspective. My current work aims to understand how telehealth can be used to reduce barriers for immigrant and non-English speaking populations, and others excluded from health care. In my California Home Abortion by Telehealth (CHAT) Study, I developed a community advisory board early on composed of reproductive justice organizations. I also invited Ena Valladares, a researcher from California Latinas for Reproductive Justice, to be a

co-investigator to help ensure that those affected most by the research could contribute towards developing the research questions.

## TEACHING AND MENTORING

### TEACHING SUMMARY

Statistical and methodological consulting, mentoring, and guest lecturing form the core of my teaching activities. I spend an average of 5 hours per week providing statistical and methodological consultation to my advisees and colleagues. I also make myself available for statistical consulting to faculty and Fellows in the Department of Obstetrics, Gynecology and Reproductive Sciences and outside the University. Currently, I do not have formal teaching responsibilities in my department but I enthusiastically seek out opportunities to guest lecture courses on quantitative research methods and reproductive health. Since I joined UCSF in 2009, I have provided several lectures on contraceptive technology, measurement of women's empowerment, and contraception and abortion.

### FORMAL TEACHING

| Not UCSF | Academic Yr | Course No. & Title | Teaching Contribution | School | Class Size |
|---|---|---|---|---|---|
| | 2009 - 2009 | S248 Globalization and Global Health, UCSF | Lecturer; 1 lecture | Nursing | 15 |
| | 2009 - 2009 | Medication Abortion, UCSF | Lecturer; 1 lecture | | 20 |
| | 2009 - 2009 | S289a Quantitative Research Methods, UCSF | Lecturer; 1 lecture | Nursing | 20 |
| | 2011 - 2011 | S289a Quantitative Research Methods, UCSF | Lecturer; 1 lecture | Nursing | 20 |
| | 2013 - 2013 | EPI 254: Social Epidemiology: Methods, Measures, and Concepts, UCSF | Lecturer; 1 lecture | Medicine | 12 |
| X | 2013 - 2013 | Women's Empowerment: Measurement, Meaning, and Making a Difference in Future Research, University of California, Berkeley | Lecturer; 1 lecture | | 20 |

| Not UCSF | Academic Yr | Course No. & Title | Teaching Contribution | School | Class Size |
|---|---|---|---|---|---|
| | 2015 - 2015 | EPI 254: Social Epidemiology: Methods, Measures, and Concepts, UCSF | Lecturer; 1 lecture | Medicine | 15 |
| X | 2015 - 2015 | Education, empowerment, and fertility, University of California, Berkeley | Lecturer; 1 lecture | | 30 |
| X | 2017 - 2017 | Gender and Global Health, Emory University, School of Public Health | Lecturer; 1 lecture | | 50 |
| X | 2020 - 2020 | Survey Research Methods, Complex Family Planning Fellowship Research Course | Lecturer; 1 lecture | | 30 |

## INFORMAL TEACHING

2008 - Reproductive Health, University of Michigan, Ann Arbor, MI

2011 - Advanced EndNote for Reproductive Research, San Francisco, CA

2012 - Women's Empowerment: Measurement, Meaning, and Making a Difference in Future Research, Seminar at Women's Health and Empowerment Retreat, Mill Valley, CA

2014 - Obstetrics, Gynecology & Reproductive Sciences Grand Rounds

2015 - "Incidence of emergency department visits and complications after abortion" Physicians for Reproductive Health Webinar (1 lecture)

2015 - "Gender-based power among adolescents and young women in the United States" Philip R. Lee Institute for Health Policy Studies (1 lecture)

2016 - "Women's Experiences with State-Level Abortion Restrictions in 5 States" Obstetrics, Gynecology & Reproductive Sciences Grand Rounds

2017 - State Regulation of Medication Abortion, EXPLAINED: Abortion Research & Policy Online Video Lectures

## MENTORING SUMMARY

Statistical and methodological consulting, mentoring, and guest lecturing form the core of my teaching activities. I spend an average of 5 hours per week providing statistical and methodological consultation to my advisees. I also make myself available for statistical consulting to faculty and Fellows in the Department of Obstetrics, Gynecology and Reproductive Sciences and outside the University. Currently, I do not have formal teaching

responsibilities in my department but I enthusiastically seek out opportunities to guest lecture courses on quantitative research methods and reproductive health. I regularly give one or two guest lectures per year, teaching when invited by faculty colleagues.

**PREDOCTORAL STUDENTS SUPERVISED OR MENTORED**

| Dates | Name | Program or School | Mentor Type | Role | Current Position |
|---|---|---|---|---|---|
| 2009 - 2012 | Rachel Goldstein | PACCTR Program, UCSF, Medical Student | Research/Scholarly Mentor,Project Mentor | Research Advisor | Clinical Assistant Professor |
| 2013 - 2013 | Roxanne Cu, RN, MSN | UCSF Global Health Clinical Scholar, NP Student | Research/Scholarly Mentor,Project Mentor | Research Advisor | Registered Nurse - San Francisco General Hospital |
| 2011 - 2014 | Deborah Karasek, MPH | UC Berkeley, Public Health | Career Mentor | Research Advisor | Assistant Professor, UCSF |
| 2011 - present | Sheila Desai, MPH | Doctoral Student, City University of New York | Career Mentor | Statistical Advisor | Senior Research Associate, Guttmacher Institute |
| 2013 - 2018 | E. Angel James, CNM, WHNP-BC | UCSF School of Nursing Doctoral Student | Research/Scholarly Mentor,Project Mentor | Research Advisor | Staff Clinician, Family Planning Associates |
| 2015 - present | Ann Fefferman | UC Irvine, Dept. of Sociology Doctoral Student | Research/Scholarly Mentor,Project Mentor,Career Mentor | Research Advisor and Dissertation Committee Member | Postbac Program, Tufts University |
| 2016 - 2018 | Natasha Mehta, MS | University of Illinois at Chicago Medical Student | Research/Scholarly Mentor,Project Mentor | Research Advisor | University of Illinois at Chicago Medical Student |

| Dates | Name | Program or School | Mentor Type | Role | Current Position |
|---|---|---|---|---|---|
| 2017 - present | Iris Jovel | UCSF, Medical Student | Research/Scholarly Mentor,Project Mentor | Yearlong Inquiry Program Mentor | UCSF, Resident |
| 2018 - present | Alice Cartwright, MPH | University of North Carolina, Gillings School of Global Public Health Doctoral Program | Research/Scholarly Mentor,Project Mentor,Career Mentor | Research Advisor | University of North Carolina Public Health Doctoral Student |
| 2018 - present | Phoebe Danza, MPH | Keck School of Medicine of the University of Southern California | Research/Scholarly Mentor,Project Mentor | Research Advisor | Supervising Epidemiologist, LA County Department of Health |
| 2019 - present | Ariana Bennett, MPH | UC Berkeley School of Public Health | Research/Scholarly Mentor,Project Mentor | Research Advisor | UC Berkeley School of Public Health Doctoral Student |
| 2019 - present | Sarah Raifman, MS | UCSF Department of Epidemiology & Biostatistics Doctoral Program | Research/Scholarly Mentor,Project Mentor | Research Advisor | UCSF Epidemiology & Biostatistics Doctoral Student |
| 2019 - present | Jackie Castellanos, MS | UC Berkeley-UCSF Joint Medical Program | Research/Scholarly Mentor,Project Mentor | Research Advisor | MD-MS Student at UC Berkeley-UCSF Joint Medical Program |
| 2018 - present | Sarah Combellick, MPH | UC Davis Sociology Department | Research/Scholarly Mentor,Career Mentor | Research Advisor | UC Davis Sociology Doctoral Student |

| Dates | Name | Program or School | Mentor Type | Role | Current Position |
|---|---|---|---|---|---|
| 2018 - present | Katherine Mcclendon, MS | UCSF School of Nursing | Project Mentor,Career Mentor | Research Advisor | UCSF School of Nursing Post Doctoral Student |
| 2018 - present | Zahra Goliaei, MD, MPH | UC Merced Public Health Department | Research/Scholarly Mentor,Career Mentor | Research Advisor | UC Merced Public Health Post Doctoral Student |
| 2019 - present | Chris Ahlbach | UCSF Medical Student | Research/Scholarly Mentor | Yearlong Research mentor | UCSF Medical Student |
| 2020 - present | Leah Koenig, MPH | UCSF Department of Epidemiology & Biostatistics Doctoral Program | Research/Scholarly Mentor,Project Mentor,Career Mentor | Research Advisor | UCSF Department of Epidemiology & Biostatistics Doctoral Program |
| 2021 - present | May Nguyen | UCSF Medical Student | Research/Scholarly Mentor,Project Mentor | Deep Explore Project Mentor | UCSF Medical Student |
| 2021 - present | Betsy Pleasants, MPH | UC Berkeley School of Public Health doctoral student | Research/Scholarly Mentor,Project Mentor,Career Mentor | Research Advisor | UC Berkeley School of Public Health |

**POSTDOCTORAL FELLOWS AND RESIDENTS MENTORED**

| Dates | Name | Fellow | Mentor Role | Faculty Role | Current Position |
|---|---|---|---|---|---|
| 2011 - 2011 | Nerys Benfield, MD | UCSF Clinical Fellow in Family Planning | Project Mentor | Research Advisor | Assistant Professor, Albert Einstein College of Medicine |

| Dates | Name | Fellow | Mentor Role | Faculty Role | Current Position |
|---|---|---|---|---|---|
| 2012 - 2014 | Chava Kahn, MD | University of Michigan Clinical Fellow in Family Planning | Research/Scholarly Mentor,Project Mentor | Statistical Advisor | Clinical Lecturer, Obstetrics & Gynecology |
| 2012 - 2014 | Elizabeth Uy-Smith, MD | UCSF SOM Primary Care Research Fellow | Project Mentor | Research Advisor | Associate Physician, UCSF School of Medicine, Family Community Medicine |
| 2014 - 2018 | Alison El Ayadi, ScD MPH | Assistant Researcher | Research/Scholarly Mentor,Career Mentor | Research Advisor | Assistant Professor |
| 2014 - present | Nadia Diamond-Smith, PhD | Postdoctoral Fellow | Research/Scholarly Mentor,Career Mentor | Research Advisor | Assistant Professor |
| 2019 - present | Stephanie Frazin, MD | UCSF Family Planning Research Fellow | Research/Scholarly Mentor,Career Mentor | Research Advisor | UCSF Family Planning Research Fellow |
| 2019 - present | Elizabeth Harrington, MD | University of Washington Family Planning Fellow | Research/Scholarly Mentor,Career Mentor | Research Advisor | University of Washington Faculty and Family Planning Fellow |
| 2020 - present | Mishka S. Peart, MD | University of North Carolina, Chapel Hill Family Planning Fellow | Research/Scholarly Mentor,Project Mentor | Research Advisor | University of North Carolina, Chapel Hill Family Planning Fellow |

### FACULTY MENTORING

| Dates | Name | Position while Mentored | Mentor Type | Mentoring Role | Current Position |
|---|---|---|---|---|---|
| 2014 - present | Nadia Diamond-Smith, PhD | Assistant Professor | Career Mentor | Career Mentor | Assistant Professor |
| 2018 - present | May Sudhinaraset, PhD | Assistant and Associate Professor | Career Mentor | Career Mentor | Associate Professor |

## RESEARCH AND CREATIVE ACTIVITIES

### RESEARCH AND CREATIVE ACTIVITIES SUMMARY

I am Associate Professor at UCSF/ANSIRH. Over the last decade I have contributed substantially to what is known about abortion safety and access and reproductive empowerment measures. My work encompasses two themes: the effects of women's empowerment and gender equity on reproductive health and improving access to reproductive health services for historically excluded populations. My methodological expertise is in quantitative analyses using epidemiologic and demographic methods. I lead several projects related to contraception and abortion that collectively aim to expand women's ability to determine the number and timing of their children and improve access to reproductive health services. I have substantial experience analyzing large datasets, published articles in high-impact peer reviewed journals, and now have a track record securing independent funding for my research. I am a frequent cited authority on abortion safety, restrictions, and medication abortion and I have published op-eds in the New York Times, USA Today, and local news outlets to amplify the science of abortion. I am also Director of Research of UCGHI's Center of Expertise in Women's Health, Gender, and Empowerment and have established myself as a global expert in the measurement of women's reproductive empowerment.

My research focuses on the following areas:

1) Abortion safety. I published a seminal article on abortion safety using data from a closed system, California's state Medicaid program. This study demonstrated that less than 0.24% of abortions resulted in a major complication and was cited by Justice Ginsburg's concurring opinion in the Whole Woman's Health v. Hellerstedt Supreme Court case. It was also cited by a NYTimes Editorial on the Supreme Court Case, June v. McGee. I have also published national emergency department data that confirmed the California findings in a more generalizable dataset. In later years, I applied this expertise providing testimony in two cases contesting new state laws related to abortion complications reporting.

2) Impact of state-level restrictions. I led several studies evaluating the impact of state-level abortion restrictions, such as Wisconsin's mandatory ultrasound viewing law, Ohio's FDA protocol requirement for medication abortion, and admitting privileges laws in several states. My research has contributed to the evidence-base that these laws have minimal impact, or they harm rather than protect people seeking abortion. I led the Google Ads Abortion Access Study which used an innovative approach to recruiting and interviewing people considering an abortion but may never reach an abortion provider. I have published 3 papers from these data and several others are under review or in draft. These methods provided insight on how state

restrictions, including Medicaid bans, create barriers, prolong the search for abortion care, and offer no benefit in terms of decision certainty.

3) Expanding access to medication abortion. My research providing data on the need for medication abortion on California's campuses was pivotal to passing SB24, Student Right to Access Act. Additionally, I have been a ferocious advocate of demedicalizing medication abortion, co-authoring the No-Test Medication Abortion protocol, analyzing safety and efficacy outcomes of telehealth for abortion, and directly advocating with the FDA to remove the REMS. I have published several Op-Eds explaining the evidence-base for removing the REMS.

4) Increasing Open Access to Science. I lead ANSIRH's abortion facility database of publicly advertising abortion providers (http://abortionfacilitydatabase.org/). My contributions to science include leading an ANSIRH-wide committee to make this database available to external researchers. My research from these data documented that there are 27 abortion deserts, major cities from which people must travel over 100 miles to reach an abortion provider. By involving historically excluded student interns I have developed a pipeline for future social science abortion researchers.

5) Research on measurement of reproductive autonomy and empowerment. Another area of my work centers on measuring gender equity. Recognizing the absence of measures for U.S.-based research, I published the first-ever theory-based, validated standardized instrument to quantitatively measure the power to decide about and control matters related to contraceptive use, pregnancy, and childbearing—The Reproductive Autonomy Scale. With support from a Career Development Award from NICH/NICHD, I developed a sexual and reproductive empowerment scale for adolescents and young adults. This work has enabled other researchers to examine empowerment and reproductive outcomes. Additionally, I developed a database of gender and empowerment measures, hosted on ANSIRH's website.

**RESEARCH AWARDS - CURRENT**

| | | | |
|---|---|---|---|
| 1. N/A (gift) | Principal Investigator | | Upadhyay (PI) |
| Individual Gifts | | 05/01/2020 | 09/30/2022 |
| The California Home Abortion by Telehealth (CHAT Study) | | $ 500,000 direct/yr 1 | $ 800,000 total |
| The goal of this project is to test the safety and efficacy of a no-test telehealth model for medication abortion. | | | |
| 2. A131550 | Principal Investigator | | Upadhyay (PI) |
| ANSIRH Core Funds | | 07/01/2020 | 06/30/2022 |
| Abortion Facility Database | | $ 120,876 direct/yr 1 | $ 184,167 total |
| To develop and maintain a database of abortion providers throughout the United States. | | | |
| 3. 7030632 | Principal Investigator | | Upadhyay (PI) |
| Tara Health Foundation | | 01/01/2020 | 12/31/2022 |
| Proof of Concept: Using Misoprostol Alone for Menstrual Regulation | | $ 171,253 direct/yr 1 | $ 322,391 total |

The major goal of this project is to assess if using misoprostol-alone for menstrual regulation is a feasible and acceptable.

4. 7500252 Principal Investigator Upadhyay (PI)
CTSI RAP Award 01/01/2021 12/31/2021
Proof of Concept: Using Misoprostol Alone for Menstrual Regulation $ 50,000 direct/yr 1 $ 50,000 total
This funding supports clinic staff for the Proof of Concept Study on a Missed Period Pill

5. OPP121659 Co-Investigator Liu, Holt (PI)
Bill and Melinda Gates Foundation 12/1/2019 12/31/2023
Building the Evidence Base for Unlocking Demand for Self-injection $ 1,713,103 direct/yr 1
The goal of the project is to understand how self-injection (SI) of DMPA-SC can be implemented to support informed contraceptive choice and use, from the perspective of women in Kenya, Malawi, Nigeria, and Uganda.

**RESEARCH AWARDS - PAST**

1. K01-HD042540 Doctoral Student Investigator Hindin (PI)
NIH/NICHD 08/28/2002 06/30/2008
Intergenerational Influences on Adolescent Transitions $ 113,182 direct/yr 1
To study the timing and predictors of demographic decisions of about 2,000 18-21 year old adolescents as they move toward adulthood among in the Cebu Longitudinal Health and Nutrition Survey. This award funds original data collection in the adolescents' cohabiting partners in 2002 and 2005 as well as expanded modules related to household decision-making and mental health in adolescents, their mothers, and their cohabiting partners.

2. No number assigned Principal Investigator/ Consultant Upadhyay (PI)
New York City Department of Health and Hygiene 09/01/2008 09/01/2009
LDL Cholesterol Levels in New York City $ 5,000 direct/yr 1 $ 5,000 total
NYC HANES is a community-based health survey modeled after the national NHANES, designed to obtain prevalence information for conditions which must be clinically diagnosed (eg. diabetes, cholesterol) for use by Department of Health programs and to better understand the burden of disease in New York City.

3. No number assigned Principal Investigator Upadhyay (PI)
Demographic and Health Surveys, Macro International 09/01/2009 12/31/2010

Women's Empowerment and Ideal Fertility in Sub-Saharan Africa — $ 5,000 direct/yr 1 — $ 5,000 total

This fellowship funded research using data from 4 sub-Saharan African countries to determine whether various measures of women's empowerment are associated with a smaller ideal number of children.

4. 5R01-HD045480-05 — Co-Investigator — Raine Bennett (PI)
NIH/NICHD — 8/11/2004 — 5/31/2010
Combined Hormonal Contraceptive Use in High Risk Women — $ 1,868,973 total

This study assesses contraceptive continuation and pregnancy rates among women using oral contraceptives, the patch, the vaginal ring, and DMPA among a group of young women at high risk of unintended pregnancy.

5. A116928 — Principal Investigator — Upadhyay (PI)
UCSF Mount Zion Health Fund — 02/11/2011 — 06/30/2012
Estimating the Incidence and Associated Costs of Post-Abortion Complications from Medi-Cal Data — $ 30,000 direct/yr 1 — $ 30,000 total

Estimating the Incidence and Associated Costs of Post-Abortion Complications from Medi-Cal Data An analysis of Medi-Cal data to examine the costs associated with complications of abortion in California.

6. No number assigned — Principal Investigator — Upadhyay (PI)
UCSF Center of Expertise, UC Global Health Institute — 11/15/2010 — 11/15/2011
Fellowship in Women's Health and Empowerment — $ 79,696 direct/yr 1 — $ 79,696 total

This Fellowship funds research and development of a reproductive empowerment index, including surveying family planning clients and psychometric evaluation of the results.

7. A107143 — Co-Investigator — Weitz (PI)
Anonymous Private Foundation — 06/01/2007 — 05/30/2014
Access Through Primary Care Initiative — $ 3,500,000 total

This project seeks to examine abortion complication rates among properly trained nurse practitioners, certified nurse midwives and physician assistants offering early aspiration abortion compared to physicians.

8. P0053793 — Principal Investigator — Upadhyay (PI)
Wellspring Advisors, LLC — 12/1/2012 — 11/30/2014
Addressing Abortion Stigma through Service Delivery — $ 64,195 direct/yr 1 — $ 111,000 total

This grant aims to develop a conceptual framework for understanding how service delivery reduces abortion stigma.

9. A124380 Principal Investigator
Mt. Zion Health Fund 11/01/2014 10/31/2015
Interest in Self-Injection of DMPA-SC Among US Family Planning and Abortion Clients $ 30,000 direct/yr 1 $ 30,000 total

10. P0053793 Principal Investigator Upadhyay (PI)
Wellspring Advisors, LLC 12/1/2012 11/30/2014
Addressing Abortion Stigma through Service Delivery $ 64,195 direct/yr 1 $ 111,000 total
This grant aims to develop a conceptual framework for understanding how service delivery reduces abortion stigma.

11. A123960 Principal Investigator
Society of Family Planning 10/01/2014 9/30/2015
Distance to an abortion provider and source of post-abortion care: Evidence from the Medi-Cal program $ 93,169 direct/yr 1 $ 93,169 total

12. A120961 Principal Investigator Upadhyay (PI)
Anonymous Private Foundation 12/01/2012 11/30/2017
Evaluation of Abortion Restrictions $ 566,670 direct/yr 1 $ 3,228,308 total

This study documents the consequences of state-level abortion restrictions across the United States.

13. A127836 Principal Investigator Upadhyay (PI)
Society of Family Planning 10/01/2016 09/30/2017
Emergency Department Visits and Major Complications After Abortion: Analysis of a Nationwide Emergency Department Sample $ 109,091 direct/yr 1 $ 120,000 total

14. No number assigned Principal Investigator Upadhyay (PI)
National Center of Excellence in Women's Health 12/01/2016 11/30/2017

| | | | |
|---|---|---|---|
| Using Google AdWords to Study Abortion Access: A Pilot Study | | $ 40,000 direct/yr 1 | $ 40,000 total |

15. Principal Investigator — Upadhyay (PI)

UCSF Clinical & Translational Science Institute (CTSI)-Pilot Awards Program — 01/01/2018 — 12/31/2018

Development of the Sexual Health and Reproductive Empowerment for Young Adults (SHREYA) Scale — $ 50,000 direct/yr 1 — $ 50,000 total

16. A127552 — Principal Investigator — Upadhyay (PI)

UCSF Clinical & Translational Science Institute (CTSI)-Pilot Awards Program — 06/01/2018 — 05/31/2019

Development of the Sexual Health and Reproductive Empowerment for Young Adults (SHREYA) Scale — $ 50,000 direct/yr 1 — $ 50,000 total

17. 1K01HD077604 — Principal Investigator — Upadhyay (PI)

NIH/NICHD — 10/1/2014 — 9/30/2019

Effects of Gender-based Power on Contraceptive Use among Young People (K01) — $ 144,586 direct/yr 1 — $ 693,324 total

18. A124803 — Co-Investigator — Greene Foster, Rocca (PI)

Anonymous Private Foundation — 07/01/2015 — 06/30/2020

Turnaway Study and Access to Abortion Study — $ 1,328,862 direct/yr 1 — $ 8,567,472 total

19. Principal Investigator — Upadhyay (PI)

ANSIRH Core Funds — 10/01/2018 — 03/31/2020

Using Google AdWords to Study Abortion Access — $ 90,680 direct/yr 1 — $ 171,401 total

20. Grant ID 5590 — Principal Investigator — Upadhyay (PI)

Anonymous Private Foundation — 09/02/2019 — 06/30/2020

Post-Roe Strategies Project $ 291,330 direct/yr $ 291,330 total
1

## PEER REVIEWED PUBLICATIONS


1. Hinrichsen D, Robey B, and **Upadhyay UD**. Freshwater Supplies and Population Growth: Finding Solutions. Renewable Resources Journal. 1999;17(3):15-21.
2. **Upadhyay UD**, Robey B. Why family planning matters. Popul Rep J. 1999 Jul; (49):1-31.
3. Robey B, **Upadhyay U**. Speeding the reproductive revolution. People Planet. 1999; 8(1):18-9.
4. Hinrichsen D, Robey B, **Upadhyay UD**. Toward a blue revolution. Glob Issues. 1999 Mar; 4(1):38-43.
5. **Upadhyay UD**. India's New Economic Policy of 1991 and Its Impact on Women's Poverty and AIDS. Journal of Feminist Economics. 2000; 6(3):105-122.
6. **Upadhyay UD.** Informed choice in family planning. Helping people decide. Popul Rep J. 2001; (50):1-39. PMID: 11552404
7. **Upadhyay UD**, Hindin MJ. Do higher status and more autonomous women have longer birth intervals? Results from Cebu, Philippines. Soc Sci Med. 2005 Jun; 60(11):2641-55. PMID: 15814188
8. **Upadhyay UD.** New contraceptive choices. Popul Rep M. 2005 Apr; (19):1-23. PMID: 15945266
9. **Upadhyay UD**, Hindin MJ. Do perceptions of friends' behaviors affect age at first sex? Evidence from Cebu, Philippines. J Adolesc Health. 2006 Oct; 39(4):570-7. PMID: 16982393
10. **Upadhyay UD**, Hindin MJ, Gultiano S. Before first sex: gender differences in emotional relationships and physical behaviors among adolescents in the Philippines. Int Fam Plan Perspect. 2006 Sep; 32(3):110-9. PMID: 17015240
11. **Upadhyay UD**, Hindin MJ. The influence of parents' marital relationship and women's status on children's age at first sex in Cebu, Philippines. Stud Fam Plann. 2007 Sep; 38(3):173-86. PMID: 17933291
12. Thorpe LE, **Upadhyay UD**, Chamany S, Garg R, Mandel-Ricci J, Kellerman S, Berger DK, Frieden TR, Gwynn C. Prevalence and control of diabetes and impaired fasting glucose in New York City. Diabetes Care. 2009 Jan; 32(1):57-62. PMID: 19114627. PMCID: PMC2606831
13. Gultiano S, Hindin M, Upadhyay U. . Marital Status and Psychological Well-Being of Filipino Women. Philippine Population Review. 2009; 8(1):16-33.
14. Gultiano S, Hindin M, Upadhyay U. . Marital Status and Psychological Well-Being of Filipino Women. Philippine Population Review. 2009; 8(1):16-33.
15. Gultiano S, Hindin M, **Upadhyay U**. . Marital Status and Psychological Well-Being of Filipino Women. Philippine Population Review. 2009; 8(1):16-33.

16. Rajpathak SN, Gupta LS, Waddell EN, **Upadhyay UD**, Wildman RP, Kaplan R, Wassertheil-Smoller S, Wylie-Rosett J. Elevated risk of type 2 diabetes and metabolic syndrome among Asians and south Asians: results from the 2004 New York City HANES. Ethn Dis. 2010; 20(3):225-30. PMID: 20828094

17. **Upadhyay UD**, Waddell EN, Young S, Kerker BD, Berger M, Matte T, Angell SY. Prevalence, awareness, treatment, and control of high LDL cholesterol in New York City, 2004. Prev Chronic Dis. 2010 May; 7(3):A61. PMID: 20394700. PMCID: PMC2879993

18. **Upadhyay UD**, Cockrill K, Freedman LR. Informing abortion counseling: an examination of evidence-based practices used in emotional care for other stigmatized and sensitive health issues. Patient Educ Couns. 2010 Dec; 81(3):415-21. PMID: 20926226

19. Raine TR, Foster-Rosales A, **Upadhyay UD**, Boyer CB, Brown BA, Sokoloff A, Harper CC. One-year contraceptive continuation and pregnancy in adolescent girls and women initiating hormonal contraceptives. Obstet Gynecol. 2011 Feb; 117(2 Pt 1):363-71. PMID: 21252751. PMCID: PMC3154007

20. **Upadhyay UD**, Brown BA, Sokoloff A, Raine TR. Contraceptive discontinuation and repeat unintended pregnancy within 1 year after an abortion. Contraception. 2012 Jan; 85(1):56-62. PMID: 22067792. PMCID: PMC3230736

21. **Upadhyay UD**. Addressing reproductive autonomy to prevent repeat unintended pregnancy. Contraception. 2012 Oct; 86(4):425-6.

22. **Upadhyay UD**, Karasek D. Women's empowerment and ideal family size: an examination of DHS empowerment measures in Sub-Saharan Africa. Int Perspect Sex Reprod Health. 2012 Jun; 38(2):78-89. PMID: 22832148

23. Goldstein RL, **Upadhyay UD**, Raine TR. With pills, patches, rings, and shots: who still uses condoms? A longitudinal cohort study. J Adolesc Health. 2013 Jan; 52(1):77-82. PMID: 23260838. PMCID: PMC3745283

24. Jones RK, Upadhyay UD, Weitz TA. At what cost? Payment for abortion care by U.S. women. Womens Health Issues. 2013 May-Jun; 23(3):e173-8. PMID: 23660430

25. Kimport K, **Upadhyay UD**, Foster DG, Gatter M, Weitz TA. Patient viewing of the ultrasound image prior to abortion. Contraception. 2013 Nov; 88(5):666-70. PMID: 24028750

26. Foster DG, Dobkin LM, **Upadhyay UD**. Denial of abortion care due to gestational age limits. Contraception. 2013 Jan; 87(1):3-5. PMID: 23122688

27. Weitz TA, Taylor D, Desai S, **Upadhyay UD**, Waldman J, Battistelli MF, Drey EA. Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver. Am J Public Health. 2013 Mar; 103(3):454-61. PMID: 23327244. PMCID: PMC3673521

28. Foster DG, Dobkin LM, **Upadhyay UD**. Denial of abortion care due to gestational age limits. Contraception. 2013 Jan; 87(1):3-5.

29. Jones RK, **Upadhyay UD**, Weitz TA. At what cost? Payment for abortion care by U.S. Women. Womens Health Issues. 2013 May-Jun; 23(3):e173-8.

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## BOOKS AND CHAPTERS

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## OTHER PUBLICATIONS

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2. **Upadhyay UD** and Karasek D. 2010. Women's Empowerment and Achievement of Desired Fertility in Sub-Saharan Africa. DHS Working Papers No. 80. Calverton, Maryland, USA: ICF Macro.

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## CONFERENCE ABSTRACTS

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16. **Upadhyay UD**, Foster DG. Denial of abortion due to advanced gestational age in the United States. Oral presentation at the 2012 Annual Meeting of the American Public Health Association. San Francisco, CA. October 30, 2012.

17. **Upadhyay UD.** Effects of receiving or being denied an abortion on American women's well-being: select findings from the first two years of the Turnaway Study. Oral presentation at the 2013 North American Forum on Family Planning. Seattle, WA October 6, 2013.

18. **Upadhyay UD**. Prevalence of Abortion Complications and Incidence of Emergency Room Visits Among 55,00 Abortions Covered by the California Medi-Cal Program. Oral presentation at the 2013 North American Forum on Family Planning. Seattle, WA October 6, 2013.

19. **Upadhyay UD**, Biggs MA, Foster DG. Does having an abortion enable women to achieve life plans? Results from the Turnaway Study. Oral presentation at the 2014 Annual Meeting of the Population Association of America. Boston, MA May 2, 2014.

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25. **Upadhyay UD**. Measuring abortion stigma. Oral presentation at the Abortion Stigma Measurement Meeting. Chicago, IL November 16, 2015.

26. **Upadhyay UD**, Zlidar VM. Interest in Self-Administration of Subcutaneous Depot Medroxyprogesterone Acetate in the United States. Oral presentation at the 2016 Annual Meeting of the Population Association of America. Washington, DC March 31, 2016.

27. Fefferman A, **Upadhyay UD**. "It Helps Me, Not You": Reproductive Autonomy, Masculinities, and Contraception Among Young Men and Women. Poster presentation at the 2016 Annual Meeting of the Population Association of America. Washington, DC April 1, 2016.

28. **Upadhyay UD**. Distance travelled and source of care after abortions: Evidence from the California state Medicaid Program. Oral presentation at the 2016 North American Forum on Family Planning. Denver, CO November 5, 2016.

29. **Upadhyay UD**, Kimport K, Belusa EKO, Johns NE, Laube D, Roberts SCM. Evaluating the impact of a mandatory ultrasound viewing law in Wisconsin: A mixed methods study. Oral presentation at the National Abortion Federation Annual Meeting. Montreal, Quebec. April 24, 2017.

30. **Upadhyay UD.** Using Google AdWords to Recruit Women Considering Abortion: Methods of a Pilot Study. Oral Presentation at the 2017 Psychosocial Workshop. Chicago, IL. April 25, 2017.

31. **Upadhyay UD**. Using Google AdWords to Recruit Women Considering Abortion: Methods of a pilot study. Oral Presentation at the 2017 North American Forum on Family Planning. Atlanta, GA October 14, 2017.

32. **Upadhyay UD**. Performance improvement through quality- and rights-based lenses: new individual experience measures from across the globe. Oral presentation at the 2017 North American Forum on Family Planning. Atlanta, GA October 15, 2017.

33. **Upadhyay UD**. Sharing research with allies and advocates outside academia and medicine. Oral Presentation at the 2017 North American Forum on Family Planning. Atlanta, GA October 16, 2017.

34. **Upadhyay UD**. Abortion-related emergency department visits: Analysis of a national emergency department sample. Oral presentation at the National Abortion Federation Annual Meeting. Seattle, WA. April 23, 2018.

35. **Upadhyay UD**, Johns NE, Barron R, Cartwright AF, Mierjeski A, Tape C, McGregor A. Abortion-Related Emergency Department Visits: Analysis of a National Emergency Department Sample. Oral presentation at the Population Association of American Annual Meeting. Denver, CO. April 26, 2018.

36. Joffe C, Kasdan D, Linkin F, **Upadhyay UD**. Fighting for the best, preparing for the worst: looking to existing research and preparing for documentation in potential 'post-Roe' landscape. Oral presentation at the North American Forum on Family Planning. New Orleans, LA. October 20, 2018.

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38. Jones R, Kavattur P, Myrick A, **Upadhyay UD**. Situating public health researchers in the US abortion judicial debate. Oral presentation at the Society of Family Planning Annual Meeting. Los Angeles, CA. October 19, 2019.

39. Borrero S, Nguyen B, Sanders J, **Upadhyay UD**, White K. "It's her body:" Men's perspectives on their role in contraception and strategies for positive engagement. Oral presentation at the Society of Family Planning Annual Meeting. Los Angeles, CA. October 21, 2019.

## OTHER CREATIVE ACTIVITIES

1. See family planning handbook (Zlidar, Upadhyay, and Lande) published in 2006 which provides technical guidance on the provision of contraceptive methods. Used to train medical students and health care providers within programs affiliated with the World Health Organization and the US Agency for International Development. Translated into 10 languages.

**IN THE DISTRICT COURT OF OKLAHOMA COUNTY**
**STATE OF OKLAHOMA**

OKLAHOMA CALL FOR REPRODUCTIVE JUSTICE, on behalf of itself and its members; TULSA WOMEN'S REPRODUCTIVE CLINIC, LLC, on behalf of itself, its physicians, its staff, and its patients; ALAN BRAID, M.D., on behalf of himself and his patients; COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, INC., on behalf of itself, its physicians, its staff, and its patients; and PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, on behalf of itself, its physicians, its staff, and its patients,

Plaintiffs,

v.

JOHN O'CONNOR, in his official capacity as Attorney General for the State of Oklahoma; DAVID PRATER, in his official capacity as District Attorney for Oklahoma County; STEVE KUNZWEILER, in his official capacity as District Attorney for Tulsa County; LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; KATIE TEMPLETON, in her official capacity as President of the Oklahoma State Board of Osteopathic Examiners; LANCE FRYE, in his official capacity as the Commissioner of the Oklahoma State Board of Health; and JUSTIN WILSON, in his official capacity as the President of the Oklahoma State Board of Pharmacy; as well as their employees, agents, and successors,

Defendants.

CASE NO._____

**AFFIDAVIT OF JOEY BANKS, M.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY INJUNCTION**

Dr. Joey Banks declares and states the following:

1. I am a board-certified family medicine physician. I provide abortion care, including medication abortion and procedural abortion up to 18 weeks LMP, at Tulsa Women's Reproductive Clinic ("Tulsa Women's"), a Plaintiff in this case. Since 2012, I have also provided care at Blue Mountain, an independent primary and family medicine clinic in Missoula, Montana, where I was Reproductive Health Medical Director for some time. For nine of my years at Blue Mountain, I served as a community preceptor, teaching abortion care to a variety of doctors, including family medicine residents and medical students. Since 2019, I have also provided reproductive healthcare at Planned Parenthood of Montana, where I formerly served as Chief Medical Officer. In earlier parts of my career, prior to 2012, I worked for the Alaska Native Health System practicing family medicine and obstetrical delivery. From 2009 to 2010, I served as the Medical Director of Planned Parenthood Alaska, where I supervised medical staff at two clinics in the state. I also served as faculty for Central Maine Medical Center and Alaska Family Practice residencies teaching residents family medicine, obstetrics, and reproductive care.

2. I am board-certified as a family medicine physician by the American Board of Family Medicine. I received my M.D. from Indiana University School of Medicine and completed my residency in family medicine at the Alaska Family Medicine Residency in Anchorage, Alaska, where I also served as chief resident.

3. During my family medicine residency, I was trained in family medicine, obstetrics, and reproductive care. This included a rotation during which I observed abortion procedures at a local clinic.

4. I have been a practicing family medicine physician for over 20 years, with extensive experience providing the full range of reproductive healthcare, particularly in rural settings, including abortion care, gynecological care, vasectomies, and labor and delivery care.

While I now specialize in abortion care, I still provide a range of reproductive healthcare, including cancer screenings, endometrial and cervical biopsies, testing and treatment for sexually transmitted infections, contraceptive implant insertions and removals, colposcopy, LEEP, ultrasound, ectopic medical care, and miscarriage management. I keep my board certification and continuing education up to date for my family medicine specialty.

5. I am currently licensed to practice medicine in Montana, Oklahoma, and Idaho. I have inactive licenses in Maine and Alaska.

6. I was born and raised in Tulsa, Oklahoma. I have provided care around the country for over twenty years and practiced here in Oklahoma for almost three years.

7. Over the course of my clinical career, I have worked closely with a wide array of clinicians who provide high quality abortion care consistent with their training, including OB/GYNs, emergency room physicians, anesthesiologists, and family medicine physicians. I am also familiar with and have trained advanced practice clinicians ("APCs") who are competent to provide medication abortion and early procedural abortion.

8. I have received grants from Reproductive Health Education in Family Medicine ("RHEDI") to teach family medicine clinicians and residents abortion and miscarriage management at both Central Maine Medical Center and Family Medicine Residency of Western Montana. RHEDI has developed a leading evidence-based curriculum for teaching abortion to family medicine clinicians and residents. I also work with Training in Early Abortion for Comprehensive Healthcare ("TEACH"), Reproductive Health Access Project ("RHAP"), and I am a member of the American Academy of Family Physicians ("AAFP"), the Society of Family Planning ("SFP"), and the American College of Obstetricians and Gynecologists ("ACOG").

9. A current version of my curriculum vitae, which sets out my experience and credentials more fully, is attached to this declaration as Exhibit A.

10. The opinions in this affidavit are based on my education, training, clinical and teaching experience, research, ongoing review of professional literature, and attendance at professional conferences.

***H.B. 1904 (the "OB/GYN" Requirement) serves no medical purpose and will drastically restrict abortion access in Oklahoma.***

11. I understand that one of the laws challenged in this case, the OB/GYN requirement, requires physicians providing abortion in Oklahoma to be board-certified in obstetrics and gynecology. I understand that a violation of this law is a felony, punishable by one to three years in prison.

12. In my opinion, this requirement has no medical basis and will significantly reduce the number of providers, and thus access to abortion, in Oklahoma.

13. Three physicians who provide abortion care at Tulsa Women's are board-certified family medicine physicians, including myself. We make up half of the physicians who provide abortion care at the clinic. At Tulsa Women's, I am also one of three physicians who regularly provides procedural abortions up to 18 weeks LMP. One of the other physicians at Tulsa Women's who provides procedural abortions up to this stage in pregnancy is also a family medicine physician. H.B. 1904 will thus disqualify three highly trained physicians at Tulsa Women's who provide the majority of procedural abortions, as well as other doctors in the state who are not board-certified in obstetrics and gynecology.

***Experience and training—not specialty—determines competence to provide abortion care.***

14. Based on my years of experience providing abortion care, working with other abortion providers, and training other clinicians to provide abortion care, it is my opinion that

specialty is not determinative of whether a clinician will be competent to provide abortion care. Proper training and experience is.

15. The training I received and provide to other clinicians includes multiple components. I train clinicians in all aspects of procedural abortion and the medication abortion regimen. My training involves lecturing, observation, and one-on-one practical teaching at sites. I have trained approximately 150 clinicians, and I have trained clinicians all over the country, including in a diverse range of settings. Though complications are rare, I teach trainees how to recognize and handle even very rare complications, whether that means treating the patient themselves or referring them to specialists or emergency care if necessary. Critically, I provide training in patient counseling—counseling around abortion requires patient-centered care, respect, compassion, and non-judgmental communication. It is essential in abortion care to facilitate the patient in making the decision that is right for them, their health, and their families.

16. In my extensive experience providing and teaching abortion care, a range of physicians across specialties can become skilled abortion providers. It is also well-established that APCs can provide early abortion as safely and effectively as physicians.[1]

17. There is no special element of the OB/GYN residency that makes OB/GYNs any more qualified to provide—or learn how to provide—abortion than physicians with other specialties, such as family medicine. OB/GYNs are not required to train in abortion care. In my

[1] Tracy A. Weitz, et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician-Assistants Under a California Legal Waiver*, 103.3 Am. J. Pub. Health 454-61 (2013), https://ajph.aphapublications.org/doi/10.2105/AJPH.2012.301159; ACOG, Comm. on Health Care for Underserved Women, *Committee Opinion No. 815, Increasing Access to Abortion* 136(6) Obstetrics & Gynecology e107-15 (Dec. 2020) (replaces Committee Opinion No. 613, Nov. 2014) ("ACOG Comm. Op. 815"), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2020/12/increasing-access-to-abortion.pdf.

professional experience, I have encountered many OB/GYNs who do not provide abortion. One survey of residency program directors found that "only 51% of obstetrics and gynecology residency programs offered routine abortion training."[2] Medical training programs have routinely reached out to me, a family medicine specialist, to be an educator and train students, residents (including OB/GYN residents), and fellows in the provision of abortion care.

18. For these reasons, ACOG characterizes requirements that "clinicians who provide abortion must be board certified obstetrician-gynecologists" as "medically unnecessary requirements designed to reduce access to abortion" because "clinicians in many medical specialties can provide safe abortion services."[3]

19. ACOG has also repeatedly reaffirmed that "[s]afe, legal abortion is a necessary component of comprehensive health care."[4] Consistent with this, ACOG recommends expanding "[t]he pool of clinicians who provide first-trimester medication and aspiration abortion to appropriately trained and credentialed advanced-practice clinicians in accordance with individual state licensing requirements."[5]

20. Indeed, in my experience providing abortion training, I have not found any difference in the abilities of OB/GYNs and family medicine doctors in their ability to become highly skilled abortion providers.

***Family practice physicians are trained in holistic medical care, which is highly compatible with providing high quality abortion care.***

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[2] ACOG, Comm. on Health Care for Underserved Women, *Committee Opinion 612, Abortion Training and Education*, 124(5) Obstetrics & Gynecology 1055-59 (Nov. 2014, reaff'd 2017) ("ACOG Comm. Op. 612"), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2014/11/abortion-training-and-education.pdf.

[3] ACOG Comm. Op. 815.

[4] *Id.*

[5] *Id.*

21. To become board-certified in family medicine, one must apply to, be accepted by, and complete a three-year family medicine residency program, which includes rotations in various specialties. A physician must then prepare for and pass a board exam. To obtain board-certification in a new specialty, such as OB/GYN, a physician would have to repeat this entire process—including applying to, being accepted by, and completing another multi-year residency program and then preparing for and passing another board exam.

22. Family medicine doctors are often uniquely positioned to be competent abortion providers. The family medicine specialty is directed at treating the whole person—from pediatrics through elder care. Many family medicine physicians provide primary care to whole families. The goal is continuity and holistic care—our training enables us to see the big picture of what is happening in a patient's life and health. In service of this goal, family medicine residencies place an emphasis on counseling and patient interaction.

23. The scope of practice for family medicine physicians can include a large array of procedures in which individual physicians may achieve competency through training and experience. Some of these procedures are comparable to or riskier than abortion. For example, some family medicine physicians learn to perform colonoscopies or vasectomies. Others provide obstetrical care including prenatal care and delivery, as I did early in my career, and childbirth is far riskier than abortion.[6] Many family medicine doctors manage miscarriages, which involves the same procedures and technical skills as abortion care.[7]

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[6] Elizabeth Raymond & David Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2 pt. 1) Obstetrics & Gynecology 215-19 (2012), https://pubmed.ncbi.nlm.nih.gov/22270271/.

[7] Linda W. Prine and Honor MacNaughton, *Office Management of Early Pregnancy Loss*, 84(1) Am. Fam. Physician 75 (2011), https://www.aafp.org/afp/2011/0701/afp20110701p75.pdf.

24. The scope of practice for family medicine physicians can also include the use of a range of prescription drugs. For example, family medicine physicians routinely prescribe medications that are comparable to or risker than medication abortion, such as antibiotics or pain medications like fentanyl. And, as mentioned above, many family medicine doctors (as well as various other types of clinicians) provide miscarriage management.[8] Managing a miscarriage by medication is typically identical to the medication abortion regimen.[9]

25. Though complications from abortion are rare, family medicine physicians are competent to manage and treat complications that arise from both procedural and medication abortion. Like clinicians in many other specialties, including OB/GYN, family medicine physicians are also competent to determine the need for a referral if the patient develops a health condition that they are unable to treat.

26. Indeed, the National Academies of Sciences, Engineering, and Medicine reviewed studies of the safety of abortion care as conducted by family medicine practitioners and found that "[a]ll complications were minor and managed effectively at rates similar to those in OB/GYN practices and specialty abortion clinics."[10] The report concluded that family medicine practitioners could provide safe and effective procedural and medication abortion care.

***There is a dearth of abortion providers and training in the United States and disqualifying competent clinicians harms patients.***

27. I do not live in Oklahoma, but travel to the state to provide abortion care. I also provide at multiple clinics across Montana. The primary reason I travel to clinics to provide care

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[8] *Id.*

[9] Courtney A. Schreiber, et al., *Mifepristone Pretreatment for the Medical Management of Early Pregnancy Loss* 378(23) New Eng. J. Med. 2161 (2018), https://www.nejm.org/doi/pdf/10.1056/NEJMoa1715726.

[10] Nat'l Acads. Of Scis., Eng'g., & Med. *The Safety and Quality of Abortion Care in the United States*, at 105 (2018), http://nap.edu/24950.

is because of the need for abortion providers in these rural states. Like me, many of my colleagues at Tulsa Women's and in Montana also travel to provide care.

28. There is shortage of abortion providers in many parts of the United States, and few institutions are committed to providing training in abortion care. Clinicians often have to seek out sufficient training in abortion care because there is either no training or too little training in their education programs. Concentrated programs have tried to fill the gap—including the RHEDI program which provides and supports abortion and miscarriage training in family medicine residencies.[11] As mentioned above, I have taught at the RHEDI program at both Central Maine Medical Center and Family Medicine Residency of Western Montana—providing both preceptor lectures and one-on-one practical teaching in clinic. Indeed, programs like these recognize that family medicine physicians, "given their broad scope and diverse geographic practice regions," are particularly "well positioned to increase abortion access" in "abortion deserts."[12] Unfortunately, despite these programs, the supply of providers continues to fall short of the need.[13] This is particularly true in the rural areas where I practice. For example, to my knowledge, I am one of only a few physicians in Montana who publicly provides dilation and evacuation ("D&E"), the most common method of abortion after approximately 14-15 weeks LMP. And at Tulsa Women's, as mentioned above, I am one of only three physicians who regularly provides procedural abortions up to 18 weeks LMP. All of this underscores that there is

[11] The Ctr. For Reprod. Health Educ. In Family Med., *What We Offer*, https://rhedi.org/about/what-we-offer/ (last visited Aug. 26, 2021).
[12] Payal Patel, et al., *Abortion Provision Among Recently Graduated Family Physicians* 52(10) Fam. Med. 724-29, https://journals.stfm.org/familymedicine/2020/november-december/paul-2020-0190/.
[13] ACOG Comm. Op. 612.

no medical reason to require abortion providers to be board-certified OB/GYNs, unless the intent is to immediately prevent a large percentage of qualified clinicians from providing abortion care.

29. Hiring physicians to provide abortion is always challenging, given the immense stigma around abortion, particularly in Oklahoma. Replacing three doctors at Tulsa Women's simultaneously would be particularly challenging, if it were possible at all, especially if they all had to be board-certified OB/GYNs. When I have hired clinicians to provide abortion, I didn't look to their specialty—I looked for their experience and training.

30. Oklahoma should not tie the hands of highly skilled providers. Doing so will dramatically restrict access to abortion and thus harm Oklahomans who need access to essential abortion care.

Dated: August 30, 2021

Joey Banks, M.D.

NOTARY

MELANIE A. GOLDSTEIN
Notary Public, Maine
My Commission Expires December 5, 2024

# EXHIBIT A

**Joey Banks, MD ABFM (she/her)**
**406-240-9440**
Joeydavidmaine@hotmail.com

## Employment

**Oct 2021 to June 1,2021** **University of Montana Genomics Core Lab**
**Laboratory Director- High Complexity Lab**
**Emergent Covid- 19 testing site for Montana**

- Provided QA and QI for lab
- Supervised testing and staff

**Jan 23, 2019, to current** **Planned Parenthood of Montana**
**Chief Medical Officer**
**Missoula Montana**
**April 2021 became interim medical director only**
**July 10th, 2021 became only contract doctor for abortion care only, Principal Investigator for Gynuity research, Moderate Complex Lab director, physician consult for US cases and as needed for other cases.**

- Staff physician- primary care and abortion
- Supervise medical staff at all statewide sites (MD, ANP, PA, RN, LPN, CA)
- Lab director Moderate Complex Lab for 5 sites. Trains and hires personnel. Provides quality assurance. Develops policy and protocol for new tests PPMT uses.
- Ensure guidelines and standard protocols are fulfilled per PP Medical Standard and Guidelines.
- Staff Clinician
- New project supervision
- PI Gynuity Research project
- PA staff supervisor
- Train residents and students
- Hire and train contract physicians
- Serve as senior leadership for PPMT and work with team to help with state-wide initiatives

**July 2012- March 2019** **Blue Mountain Clinic**
**Reproductive Health Medical Director**
**Missoula Montana**

- Staff physician- primary care
- Community preceptor for Family Medicine Residency Western Montana
- Gender affirming care hormone therapy including youth care and blockers
- Youth gender affirming care community organizer/lecturer
- Western Montana Family Medicine Resident Community Attending- award for best community attending in 2014/2020
- Awarded RHAP Miscarriage Care Initiative Grant for WMFMR and our clinic
- Assisted in RHEDI grant application and implementation
- Partnered with OAA as medical supervisor for GC/CT program testing and treatment
- LEEP, vasectomy, cryo-therapy, skin lesions, primary care, reproductive care, aspiration abortion to 18 weeks EGA, medical abortion, Accutane
- Assisted in Lab Management with lab director to hire and train personnel and to provide quality assurance and training for moderate complex lab.

**February 2010- July 2012** **Arusha Lutheran Medical Center**
**Arusha Tanzania**
**Family Physician**

- Outpatient clinic volunteer and school-based clinic/educator
- Grounds for Health volunteer for VIA training
  Prenatal, gynecology, pediatrics, family medicine
- **Sexual Abuse and Rape Care Committee chair**
  - ✓ Wrote medical policy, training program, and curriculum
- ALSO- Advanced Life Saving Obstetrics instructor
  - ✓ Modified curriculum for African medical care and policies

**2007-December 2009** **Central Maine Medical Center Family Medicine Residency**
**Lewiston ME**
**Family Physician Faculty- Inpatient/Outpatient/Obstetrics**

- Faculty
- Curriculum Committee Chair
- Gynecology Curriculum Coordinator
- **RHEDI grant coordinator**- IPAS MVA abortion, miscarriage, and ultrasound training director (200,000$ grant)- wrote curriculum, policy and initiated

**2008-December 2009** **Planned Parenthood NNE**
**Portland ME**
**Contract Physician**

- Colpo, Cryo, miscarriage care, LEEP, fetal demise and abortion care, family planning

**2005-2007** **Planned Parenthood of Alaska**
**Anchorage AK**
**Medical Director for State of AK (2 clinics)**

- Supervised medical staff at 4 clinics (MD, ANP, RN, LPN, RHS)
- Colposcopy, LEEP, vasectomy, Implanon master trainer, family practice, abortion, and gynecology health service clinician
- Assisted in writing Men's Reproductive Health Protocol for medical care for National Planned Parenthood of America
- Worked with Patient Service Director on drug formularies, lab manuals, education issues for staff, coding and billing.
- Helped with statewide education, public policy, and fundraising issues
- Lab Director for 2 sties. Moderate Complexity. Helped to establish moderate complex lab and develop policy and protocols for the lab. Hired personnel and trained staff on testing. Maintained quality assurance for the lab.

**2005-2007** **Providence Family Medicine Residency**
**Anchorage AK**
**Faculty and Gynecology/Elective/Evaluation Coordinator**

- Supervised residents in clinic and inpatient care for pediatric, obstetrical, and medical admissions.
- Developed curriculum for gynecology rotations for the residents
- " Faculty of the Year Award"- for 2006 (voted by residents)
- Managed panel of patients and did clinic outpatient visits
- Faculty for 2005-2006, then volunteer faculty 2006-2007

**2001-2005** **ANMC-Primary Care Center**
**Anchorage AK**
**Family Practice Clinician**

- Medical Student Supervisor through University of Washington
- Secretary Medical Staff ANMC 2002-2003
- PCC liaison for women's health and obstetrical care
- Village MD for Sandpoint AK (pop 3000)
- Team physician for panel of approximately 1400 patients
- Family practice care including prenatal and obstetrics
- Member of Quality Assurance PCC committee

**1998-2001** **Alaska Family Practice Residency**
**Anchorage AK**
**Providence Family Practice Resident**

- Chief Resident
- Third Year Resident Teacher of Year (2001) and Intern of the Year (1998)
- AAFP National Resident Rural Committee representative 2000

**2001-2003** **Providence Seward ER**
**Seward AK**
**ED Locum Physician**

## Contract Doctor Employment Positions:

**February 2021 to current** **Tulsa Women's Clinic**
**Tulsa, Oklahoma**

- Medical abortion, surgical abortion first and second trimester, IV sedation provider, Ultrasound provider

**April 2021 to current** **Planned Parenthood of Montana**
**Billings, Missoula, Helena Montana**

- Medical abortion, surgical abortion first and second trimester, IV sedation provider, Ultrasound provider, Abortion trainer for other physicians or residents

**March 2019 to current** **Blue Mountain Clinic Family Medicine**
**Missoula Montana**

- Medical abortion, surgical abortion first and second trimester, IV sedation provider, Ultrasound provider, Abortion trainer for other physicians or residents

**Dec 2019 to March 2020** **Trust Women**
**Oklahoma City, Oklahoma**

- Medical abortion, surgical abortion first and second trimester, IV sedation provider, Ultrasound provider

## Education

- 1998-2001 Alaska Family Medicine Residency
- 1994-1998 Indiana University School of Medicine
- 1986-1989 Baylor University- BA Sociology

## Certifications

- Board Certification Family Medicine current
- State of Alaska, Maine Physician License previous
- State of Montana, Oklahoma, Idaho Physician License current
- DEA current
- COLA Lab Director Certification- Lab Director course completion
- ACLS current

## Other/Lectures and Associations

- Contraception Update Lecturer for AAFP AK and AK PA association
- Speaker for MT AFFP meetings/statewide hospital CME (contraception update, miscarriage care, care, gender dysphoria)
- Co- Author Gynuity Research articles 2021
- Community Preceptor for WMFMR
- Ultrasound training for basic gynecology and prenatal care Lecturer STFM
- Member of AAFP, RHAP, SFP, ACOG, MT AAFP
- Peace Corps Volunteer Ghana West Africa- teacher (1990-1993)
- Merck Nexplanon master trainer 2006- current
- Residency International Experience Cameroon
- Medical School International Experience Kenya

**IN THE DISTRICT COURT OF OKLAHOMA COUNTY**
**STATE OF OKLAHOMA**

OKLAHOMA CALL FOR REPRODUCTIVE JUSTICE, on behalf of itself and its members; TULSA WOMEN'S REPRODUCTIVE CLINIC, LLC, on behalf of itself, its physicians, its staff, and its patients; ALAN BRAID, M.D., on behalf of himself and his patients; COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, INC., on behalf of itself, its physicians, its staff, and its patients; and PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, on behalf of itself, its physicians, its staff, and its patients,

Plaintiffs,

v.

JOHN O'CONNOR, in his official capacity as Attorney General for the State of Oklahoma; DAVID PRATER, in his official capacity as District Attorney for Oklahoma County; STEVE KUNZWEILER, in his official capacity as District Attorney for Tulsa County; LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; KATIE TEMPLETON, in her official capacity as President of the Oklahoma State Board of Osteopathic Examiners; LANCE FRYE, in his official capacity as the Commissioner of the Oklahoma State Board of Health; and JUSTIN WILSON, in his official capacity as the President of the Oklahoma State Board of Pharmacy; as well as their employees, agents, and successors,

Defendants.

Case No. CV-2021-2072
Hon. C. Truong

**REBUTTAL AFFIDAVIT OF ALAN BRAID, M.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY INJUNCTION**

Dr. Alan Braid declares and states the following:

1. I am a Plaintiff in this case and submitted an affidavit in support of Plaintiff's Motion for a Temporary Injunction. I have reviewed the affidavits of Ingrid Skop, M.D., and

Tabitha Danley, D.O., and the declaration of Donna Harrison, M.D., and submit this affidavit to respond to some of the statements therein. The fact that I do not respond to a particular statement therein does not mean that I agree with it.

2. First, Dr. Skop states that abortion providers have "no central professional organization that provides oversite of the clinical practice and skills" of all abortion providers.[1] However, Plaintiff Tulsa Women's Reproductive Clinic, LLC ("the Clinic") is certified by the National Abortion Federation ("NAF")[2]—a professional association of abortion providers with over 400 abortion providing facility members.[3] NAF issues Clinical Policy Guidelines for Abortion Care and conducts Quality Assurance and Improvement site visits to assess compliance with the guidelines.[4]

3. Dr. Skop asserts that too many abortion providers "operate largely without supervision."[5] I'm not familiar with any such providers. This suggestion ignores that abortion in Oklahoma is highly regulated on top of Oklahoma's generally applicable laws governing the provision of healthcare and practice of medicine. The Clinic is subject to extensive requirements, including that it is licensed by the Oklahoma State Department of Health. The reality is that the care we provide is extremely safe, effective, and high-quality. I personally have been providing safe, effective, and high-quality abortion care for over forty-five years.

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[1] Aff. of Ingrid Skop, M.D. ("Skop Aff.") ¶ 22.
[2] Aff. of Alan Braid, M.D., in Support of Pls.' Mot. for Temporary Inj. ("Braid Aff.") ¶ 8.
[3] Nat'l Abortion Fed'n, *NAF Membership*, https://prochoice.org/naf-membership/ (last visited Sept. 28, 2021).
[4] Nat'l Abortion Fed'n, *Quality/Standards*, https://prochoice.org/providers/quality-standards/ (last visited Sept. 28, 2021).
[5] Skop Aff. ¶ 22.

4. Second, Dr. Skop also suggests that the extensive and often duplicative reporting requirements in S.B. 778 and S.B. 779 are "medically appropriate and justified."[6] Oklahoma already requires each abortion and any complications—as defined by Oklahoma—to be reported.[7] As I explained in my previous affidavit, my understanding is that, under existing law, the State publishes aggregated information, but has never made individual patient records "public records."[8] In contrast, reports filed under S.B. 778 would be designated "public records."[9] There is no medical basis for this. Indeed, this requirement and S.B. 779's reporting system each raise serious security and confidentiality concerns.[10]

5. Third, Dr. Skop's suggestion that "[w]omen in Oklahoma are being steered towards medical abortions" is incorrect.[11] As I explained in my previous affidavit, when patients arrive at the Clinic, they receive counseling on the types of abortion procedures for which they are eligible.[12] Many of the Clinic's patients choose medication abortion for a variety of reasons, including privacy concerns and the ability to avoid a procedure involving the insertion of instruments.[13] Medication abortion offers increased flexibility for patients and, for those patients concerned about intimate partner violence, can appear similar to a

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[6] *Id.* ¶ 6.
[7] *See* Okla. State Dep't of Health, *Oklahoma Individual Reporting Form (Revised for Nov. 1, 2013)*, https://oklahoma.gov/content/dam/ok/en/health/health2/documents/hci-itop-individualabortionfrom20131101.pdf; Okla. State Dep't of Health, *Complications of Induced Abortion Report*, https://oklahoma.gov/content/dam/ok/en/health/health2/documents/hci-itop-complicationsinducedabortionreport.pdf (last visited Sept. 28, 2021); *see also* Okla. State Dep't of Health, *Abortion Surveillance in Oklahoma, 2002-2020*, (May 2020) (compiling reporting data), https://oklahoma.gov/content/dam/ok/en/health/health2/aem-documents/data-and-statistics/center-for-health-statistics/2020%20AbortionReport.pdf.
[8] Braid Aff. ¶¶ 78-81.
[9] *Id.*
[10] *See id.* ¶¶ 78-81, 92-94.
[11] Skop Aff. ¶ 25.
[12] Braid Aff. ¶¶ 61-64.
[13] *Id.* ¶ 65.

miscarriage. For these reasons, it is unsurprising that many patients choose medication abortion. Medication abortion can also be medically preferred for some patients.[14] This determination is made on a patient-by-patient basis. In short, the Clinic does not counsel patients towards medication abortion—not for profit, as Dr. Skop suggests, or for any other non-medical reason. Indeed, doing what Dr. Skop suggests would be a violation of our ethical obligations to our patients.

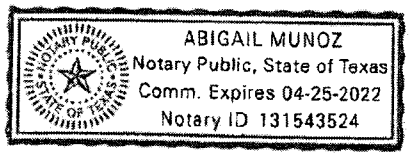
6. Fourth, three board-certified OB/GYNs currently provide abortion care at the Clinic. One of the OB/GYN-certified physicians generally provides only medication abortion at the Clinic. The other board-certified OB/GYN and I each provide medication and procedural abortions at the Clinic, but travel from out-of-state. None of the Clinic's board-certified OB/GYNs—myself included—could provide abortion care full-time at the Clinic.

[14] *Id.* ¶ 66.

Dated this 29 day of SEPT, 2021.

Alan Braid, M.D.

NOTARY



**IN THE DISTRICT COURT OF OKLAHOMA COUNTY**
**STATE OF OKLAHOMA**

OKLAHOMA CALL FOR REPRODUCTIVE JUSTICE, on behalf of itself and its members; TULSA WOMEN'S REPRODUCTIVE CLINIC, LLC, on behalf of itself, its physicians, its staff, and its patients; ALAN BRAID, M.D., on behalf of himself and his patients; COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, INC., on behalf of itself, its physicians, its staff, and its patients; and PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, on behalf of itself, its physicians, its staff, and its patients,

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JOHN O'CONNOR, in his official capacity as Attorney General for the State of Oklahoma; DAVID PRATER, in his official capacity as District Attorney for Oklahoma County; STEVE KUNZWEILER, in his official capacity as District Attorney for Tulsa County; LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; KATIE TEMPLETON, in her official capacity as President of the Oklahoma State Board of Osteopathic Examiners; LANCE FRYE, in his official capacity as the Commissioner of the Oklahoma State Board of Health; and JUSTIN WILSON, in his official capacity as the President of the Oklahoma State Board of Pharmacy; as well as their employees, agents, and successors,

Defendants.

Case No. CV-2021-2072
Hon. C. Truong

**REBUTTAL DECLARATION OF JOSHUA YAP, MD., MPH., AAHIVS IN FURTHER SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY INJUNCTION**

Joshua Yap, M.D., MPH, AAHIVS, declares the following under penalty of perjury:

1. I submit this declaration in further support of Plaintiffs' Motion for Temporary Injunction and to provided updates to this Court.

2. In recent years, Plaintiffs Comprehensive Health of Planned Parenthood Great Plaints ("CHPPGP") and Planned Parenthood Arkansas & Eastern Oklahoma ("PPAEO") have been consistently seeking to hire more physicians to provide abortion care in Oklahoma, whether OB/GYNs or otherwise, so that we can provide care to more patients.

3. As detailed in my prior declaration, it is exceedingly difficult to hire physicians to provide abortion care in Oklahoma. Ex. 3 to Plaintiffs' Motion for Temporary Injunction, Affidavit of Dr. Joshua Yap ("Yap Aff.") ¶¶ 22–28. Recently, since the Texas abortion ban went into effect, there has been some increased interest among abortion-providing physicians in providing care in Oklahoma, because so many Texas abortion patients are being forced to travel to Oklahoma due to Texas's six-week abortion ban.

4. But even with this increased interest, CHPPGP has successfully retained the services of only four new physicians to provide abortion care in Oklahoma health centers, of whom three are OB/GYNs. However, none of these doctors are available to provide full-time care, instead they are each able to provide services only approximately one to two days per month, and their long-term availability is unknown.

5. As a result, if the OB/GYN only requirement goes into effect, the availability of abortion care at CHPPGP and PPAEO will be *dramatically* reduced—reducing the number of physicians who provide care at our Oklahoma health centers by half and reducing abortion access at our health centers by substantially more than half, given that I am the only physician who provides abortion care full-time in Oklahoma. I am the only physician providing abortion

care at PPAEO's Tulsa health center and, on top of that, I also provide care at CHPPGP's Oklahoma City health center.

6. I understand that one of the Defendants' witnesses has stated that "[t]here is no central professional organization that provides oversite [sic] of the clinical practice and skills" of abortion providers.

7. In reality, the National Abortion Federation, of which CHPPGP and PPAEO are members, is a national association of abortion providers, which publishes Clinical Policy Guidelines for abortion care, available at https://prochoice.org/store/clinical-policy-guidelines/.

8. I understand the Defendants' witnesses are implying that health centers that provide abortion are totally unregulated. The reality is quite the opposite. CHPPGP and PPAEO are both specifically licensed by the state of Oklahoma to provide abortion care; their physicians, nurses and other licensed medical professionals are licensed by the Oklahoma State Board of Medical Licensure and Supervision; and both comply with Oklahoma's extensive reporting requirements, including reporting abortion complications.

9. Finally, I understand that Defendants' witnesses are stating that abortion providers are "steering" patients towards medication abortions, rather than procedural abortions. This could not be further from the truth. We provide all of our patients with full information about the methods of abortion available to them, talk to them about their options, and answer questions. Patients then choose for themselves the method that they prefer. I have discussed in my prior declaration some of the reasons why some patients strongly prefer a medication abortion. Yap Aff. ¶¶ 53.

10. The implication that I understand Defendants' witnesses to be making—that medication abortion saves the health center money—is patently absurd and simply untrue. Similarly, the implication that procedural abortion requires "pay[ing] a skilled surgeon" is an obvious misstatement—I am not a surgeon and procedural abortion does not require surgery as it is commonly understood (*i.e.* abortion care does not require an incision).

11. I have devoted my professional career to providing abortion care. I have engaged in substantial specialized training in abortion care and have provided high-quality, compassionate, and evidence-based abortion care to countless patients. I know OB/GYNs who have neither trained in nor ever provided abortion care. It is upsetting to imagine that my actual training and expertise is being discounted without any basis in logic or medicine.

12. CHPPGP and PPAEO provide high quality, evidence-based, and non-judgmental health care to all of our patients—whether they choose to continue a pregnancy or have an abortion; whether they choose a medication abortion or a procedural abortion. Our patients deserve to be able to make decisions about their own health care, in consultation with their doctors and health care team, free from ideologically-driven state regulation not grounded in medical evidence.

Dated: September 29, 2021

Joshua Yap, MD

Joshua Yap, M.D., MPH, AAHIVS

Sworn before me this 29th
day of September 2021

Felecia Martinez

Notary Public

FELECIA MARTINEZ
NOTARY PUBLIC
No. 15007205
EXP 8/06/2023
IN AND
FOR
STATE OF OKLAHOMA

**IN THE DISTRICT COURT OF OKLAHOMA COUNTY**
**STATE OF OKLAHOMA**

OKLAHOMA CALL FOR REPRODUCTIVE JUSTICE, on behalf of itself and its members; TULSA WOMEN'S REPRODUCTIVE CLINIC, LLC, on behalf of itself, its physicians, its staff, and its patients; ALAN BRAID, M.D., on behalf of himself and his patients; COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, INC., on behalf of itself, its physicians, its staff, and its patients; and PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, on behalf of itself, its physicians, its staff, and its patients,

Plaintiffs,

v.

JOHN O'CONNOR, in his official capacity as Attorney General for the State of Oklahoma; DAVID PRATER, in his official capacity as District Attorney for Oklahoma County; STEVE KUNZWEILER, in his official capacity as District Attorney for Tulsa County; LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; KATIE TEMPLETON, in her official capacity as President of the Oklahoma State Board of Osteopathic Examiners; LANCE FRYE, in his official capacity as the Commissioner of the Oklahoma State Board of Health; and JUSTIN WILSON, in his official capacity as the President of the Oklahoma State Board of Pharmacy; as well as their employees, agents, and successors,

Defendants.

Case No. 2021-2072
Hon. C. Truong

**REBUTTAL AFFDAVIT OF USHMA UPADHYAY, PH.D., M.P.H. IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY INJUNCTION**

Dr. Ushma Upadhyay declares and states the following:

1. I have reviewed the affidavits of Ingrid Skop, M.D., Donna Harrison, M.D., and Tabitha Danley, D.O., and nothing in these affidavits undermines the opinions I expressed in my prior affidavit. Rather, Dr. Skop, Dr. Harrison, and Dr. Danley put forth statements that are out of line with the medical consensus and unsupported by the credible medical evidence. I have not addressed every component of their affidavits, but my choice not to address every component should not be construed as my agreement with any their opinions.

2. As I stated in my original affidavit, abortion is one of the safest outpatient procedures performed in the United States.[1] Like any procedure, abortion has risks.[2] Those risks, however, are extremely low.[3] They are comparable to or lower than the risks associated with other common outpatient procedures like wisdom tooth extraction or colonoscopy.[4] The risks of medication abortion specifically are also extremely low.[5] As I reported in my original affidavit, they are comparable to the risks associated with antibiotics and Ibuprofen.[6]

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[1] Nat'l Acad. Sci., Eng'g, & Med., *The Safety and Quality of Abortion Care in the United States*, 2018, *available at* http://nap.edu/24950 [*hereinafter*, NAS, Safety and Quality of Abortion Care] at 74-77.

[2] Ushma D. Upadhyay, et al., *Abortion-Related Emergency Department Visits in the United States: An Analysis of a National Emergency Department Sample*, 16(88) BMC Med. 1-11, 2, 8 (2018) [hereinafter, "2018 National ED Study"], *available at* https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-018-1072-0.

[3] *Id.*; NAS, Safety and Quality of Abortion Care at 74-76.

[4] *Id.*; 2018 National ED Study at 8.

[5] Ushma D. Upadhyay, et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125(1) Obstetrics & Gynecology 175-83 (2015) [hereinafter, "2015 ED Study"], *available at* https://journals.lww.com/greenjournal/Fulltext/2015/01000/Incidence_of_Emergency_Depart me nt_Visits_and.29.aspx.

[6] NAS, Safety and Quality of Abortion Care, at 58, 79.

3. As the research I cited in my original affidavit shows—there is no medical basis for provider restrictions like the OB/GYN requirement or admitting privileges, which have been repeatedly shown to have *no impact* on patient care, contrary to the assertions of Dr. Skop.[7] Abortion care is not confined to the OB/GYN specialty—abortion by medication or aspiration fit within the scope of primary care,[8] and research shows patients actually prefer to receive abortion care from their own primary care provider.[9] Indeed, Dr. Danley has declined to take a position on the OBGYN Requirement at this time, Danley Aff. ¶ 4, and she acknowledges that family medicine physicians can learn dilation and curettage (D&C) and dilation and evacuation (D&E) procedures. *Id.* ¶ 6.

4. Dr. Skop's and Dr. Harrison's opinions that abortion is unsafe are completely out of step with the wealth of literature to the contrary. Skop Aff. ¶¶ 7-18; Harrison Aff. ¶ 27-32. I am not aware of *any* credible studies that show that abortion is unsafe.

5. As the National Academies of Sciences, Engineering, and Medicine concluded after reviewing all of the available evidence—hundreds of studies—"[t]he clinical evidence makes clear that legal abortions in the United States—whether by medication, aspiration, D&E,

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[7] Ushma D. Upadhyay, et al., *Admitting Privileges and Hospital-Based Care After Presenting for Abortion: A Retrospective Case Series*, 54(2) Health Serv. Rsch. 425-36 (2018/2019), *available at* https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.13080; NAS, Safety and Quality of Abortion Care at 15; Tracy A. Weitz, et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants under a California Legal Waiver*, 103(3) Am. J. Pub. Health 454-61 (2013), *available at* https://ajph.aphapublications.org/doi/10.2105/AJPH.2012.301159.

[8] Jessica Beaman, et al., *Medication to Manage Abortion and Miscarriage*, 35(8) J. Gen. Intern. Med. 2398-405 (2020), *available at* https://link.springer.com/article/10.1007%2Fs11606-020-05836-9.

[9] Emily M. Godrey, et al., *Women's Preference for Receiving Abortion in Primary Care Settings*, 19(3) J. Women's Health 547-53 (2010), *available at* https://pubmed.ncbi.nlm.nih.gov/20156084/.

or induction—are safe and effective."[10] Dr. Skop's criticism that this Consensus Study Report is biased and unreliable is unsupported and, indeed, unsupportable. Skop Aff. ¶ 11. "The National Academy of Sciences was established in 1863 by an Act of Congress, signed by President Lincoln, as a private, nongovernmental institution to advise the nation on issues related to science and technology."[11] Over time, it was combined with the Academies of Engineering and Medicine, and now, "[t]he three Academies work together . . . to provide independent, objective analysis and advice to the nation and conduct other activities to solve complex problems and inform public policy decisions."[12] The National Academies' Consensus Study Reports are written by independent scientists and "document the evidence-based consensus on the study's statement of task by an authoring committee of experts."[13] In their study of abortion, the National Academies convened a broad group of researchers from across research areas who reviewed hundreds of studies, relying on the highest quality research, and published a report subjected to rigorous and independent peer-review.[14] In short, the National Academies do not use "poor-quality data" and are not affiliated with a so-called "abortion industry." Skop Aff. ¶ 11.

6. Dr. Skop suggests that my studies of emergency department visits—widely known to be some of the best evidence of abortion safety—should be questioned because of a possible lack of specificity in "search engines," but that was not a component of our

[10] NAS, Safety and Quality of Abortion Care at 77.

[11] *Id.* at iii.

[12] *Id.*

[13] *Id.* at iv.

[14] *Id.* at iv, 1-2.

methodology. Skop Aff. ¶ 11. My team used an established database containing a "nationally representative sample of ED visits" from the Nationwide Emergency Department Sample (NEDS), including "947 to 964 hospitals across the U.S. per year."[15] This database has been used as a basis for hundreds of articles on a variety of medical issues. Further, as we mentioned in our study, the rate of complications we reported is possibly *overinclusive* because it may capture complications from miscarriages or self-induced abortions.[16]

7. Instead of the hundreds of recent, high-quality studies available on abortion safety,[17] both Dr. Skop and Dr. Harrison rely heavily on a few older and/or international studies, including, for example, a 2009 study of a Finnish medical database by Niinimaki, et al., in support of their position that abortion is unsafe or that the research does not accurately reflect its risks.[18] Skop Aff. ¶ 12, 26; Harrison Aff. ¶¶ 18-21. But, this study does not support these conclusions—this study documented a rate of hemorrhage of 15.6% yet did not provide a definition of hemorrhage, including any report of bleeding even if within a normal range, and it coded all follow-up visits as "complications" regardless of whether a follow-up visit actually reflected a complication.[19] The very purpose of the combination of mifepristone and misoprostol is to expel the contents of the uterus and induce bleeding; it is no wonder they saw higher rates of patient reported bleeding in the medication abortion group. For all of these

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[15] 2018 National ED Study at 2.

[16] *Id.* at 10.

[17] NAS, Safety and Quality of Abortion Care, at 80-93 (listing studies).

[18] Maarit Niinimaki, et al., *Immediate Complications after Medical Compared with Surgical Termination of Pregnancy*, 411(4) Obstetrics & Gynecology 795-804 (2009).

[19] *Id.*

reasons, the authors of the study concluded that "many of the 'complications' are not really such, but rather concerns or adverse events that bring women back to the health care system . . . [The] [r]ate of serious, 'real' complications is rare and rather similar between surgical and medical abortion."[20]

8. Dr. Skop also makes much of the fact that the federal government does not impose national reporting obligations relating to abortion complications, but that is true of myriad medical procedures as well as childbirth. Skop Aff. ¶ 13. Dr. Harrison argues from this that researchers are not able to accurately capture complications related to abortion. Harrison Aff. ¶ 12-14. To the contrary, researchers are still able to reliably collect and track representative data to advise clinicians on the risks and benefits of different procedures and medications, as many researchers, including myself, have done to demonstrate that abortion is extremely low risk.

9. Dr. Harrison references reviews she has performed of the Adverse Event Reports received by the FDA relating to mifepristone. Harrison Aff. ¶¶ 10-17. Indeed, these AERs are not reliable evidence of the safety of medication abortion, but not because they underrepresent purported complications. In my institution's review of the FDA Adverse Events Summary through December 31, 2018, we emphasize that this data shows complications associated with mifepristone at all "regardless of their likelihood of being causally linked" to an abortion.[21] In short, these reports are very imprecise evidence upon which to make a

[20] *Id.* My team's 2015 study also found a higher rate of what we termed "complications" among patients who had medication abortions—however, these were simply cases in which patients needed additional medications or an aspiration to complete the abortion.

[21] ANSIRH, *Analysis of Medication Abortion Risk and the FDA Report "Mifepristone U.S. Post-Marketing Adverse Events Summary through 12/31/2018"*, Issue Brief (Apr. 2019), *available at*

determination of the safety of medication abortion. Far more reliable and superior methods have been used by myself and many other researches, including the use of nationally representative data sets, to study the safety of medication abortion.[22]

10. In all instances, abortion is far safer than carrying a pregnancy to term.[23] Dr. Skop's assertion that the evidence of this is "conjecture" is incorrect. Skop Aff. ¶ 14. The study underlying this conclusion is a high-quality study using Centers for Disease Control and Prevention (CDC) pregnancy-related mortality data, which the CDC has long collected and has become more reliable over time.[24] The CDC takes extensive steps to investigate every death of a woman while pregnant or within 1 year of the end of pregnancy from any cause related to or aggravated by the pregnancy.[25] Medical epidemiologists review and analyze death records, linked birth records, and fetal death records.[26] In fact, this study actually underestimates pregnancy-related mortality because it excluded maternal mortality from stillbirths and ectopic pregnancies.[27]

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https://www.ansirh.org/sites/default/files/publications/files/mifepristone_safety_4-23-2019.pdf;

[22] *Id.*

[23] Elizabeth Raymond & David Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2 pt. 1) Obstetrics & Gynecology 215-19 (2012), *available at* https://pubmed.ncbi.nlm.nih.gov/22270271/.

[24] *Id.*

[25] CDC, *Pregnancy Mortality Surveillance System*, *available at* https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm.

[26] *Id.*

[27] *See* source cited *supra* n.23.

11. Dr. Skop faults physicians for using the evidence-based protocol for prescribing medication abortion up to 11 weeks LMP, Skop Aff. ¶ 24, but this use is evidence-based and supported by the literature.[28] In fact, as I discussed in my original affidavit, in 2016, the FDA updated the label to account for the ways in which doctors had been prescribing the regimen in line with medical evidence,[29] including by expanding its suggested time frame and by removing unnecessary in-person follow-up visits.[30] Clinicians can and often do prescribe medications according to the latest evidence instead of outdated labels. It is done in all areas of medicine.[31]

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[28] Nathalie Kapp, et al., *Medical Abortion in the Late First Trimester: A Systematic Review*, 99(2) Contraception 77-86 (2019), *available at* https://www.sciencedirect.com/science/article/pii/S0010782418304864; Ilana G. Dzuba, et al., *A Non-Inferiority Study of Outpatient Mifepristone-Misoprostol Medical Abortion at 64–70 days and 71–77 Days of Gestation*, 101(5) Contraception 302-8 (2020), *available at* https://pubmed.ncbi.nlm.nih.gov/32014520/.

[29] *See* source cited *supra* n.21.

[30] *Id.*

[31] Jeanie Kim & Amy Kapczynski, *Promotion of Drugs for Off-label Uses: The US Food and Drug Administration at a Crossroads*, 177(2) JAMA Internal Med., 157-8 (2017), *available at* https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2580726.

12. Dr. Skop's opinions that abortion leads to long-term health consequences like increased risk of infertility,[32] preterm birth,[33] or poor mental health[34] have been rejected based on quality medical evidence and consensus within the medical field. Skop Aff. ¶ 14-18.

13. Dr. Skop and Dr. Harrison argue that an in-person counseling visit 72-hours in advance ensures that the medication is dispensed directly to the patient, Skop Aff. ¶ 30; Harrison ¶¶ 40-41, but patients must receive medication abortion in a clinic in Oklahoma—there is no telemedicine abortion permitted, as far as I understand. Similarly, Dr. Harrison advocates for accurate ultrasonography, which is unrelated to the question of when an ultrasound should occur. Harrison Aff. ¶¶ 33-38. She also advocates for various informed consent requirements unrelated to the mandatory 72-hour ultrasound requirement. *Id.* In any event, the literature demonstrates that regret is not common after abortion, patients are

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[32] Am. C. Obstetricians & Gynecologists, *Frequently Asked Questions: Abortion Care*, *available at* https://www.acog.org/womens-health/faqs/induced-abortion ("Abortion does not increase the risk of breast cancer, depression, or infertility."); *see also* CDC, *Preterm Birth*, *available at* https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm (listing risk factors for preterm birth, which do not include induced abortion); S. Lurie, et al., *The Influence of Midtrimester Termination of Pregnancy on Subsequent Fertility: Four to Five Years Follow-up*, 50(3) Contraception 239-241 (Sep. 1994), *available at* https://pubmed.ncbi.nlm.nih.gov/7805374/; P. Frank, et al., *The Effect of Induced Abortion on Subsequent Fertility*, 100(6) Brit. J. Obstetrics & Gynecology, 575-580 (Jun. 1993), *available at* https://pubmed.ncbi.nlm.nih.gov/8334095/.

[33] NAS, Safety and Quality of Abortion Care, at 138, 146, 153.

[34] Brenda Major, et al., *Abortion and Mental Health: Evaluating the Evidence*, 64(9) Am. Psychol. 863-90 (2009), *available at* https://www.apa.org/pubs/journals/features/amp-64-9-863.pdf; Nat'l Collaborating Ctr. for Mental Health (NCCMH), Academy of Medical Royal Colleges (AMRC), *Induced Abortion and Mental Health: A Systematic Review of the Mental Health Outcomes of Induced Abortion, Including Their Prevalence and Associated Factors*, (2011), *available at* https://www.aomrc.org.uk/wp-content/uploads/2016/05/Induced_Abortion_Mental_Health_1211.pdf; Antonia Biggs, et al., *Women's Mental Health And Well-Being 5 Years After Receiving Or Being Denied An Abortion: A Prospective, Longitudinal Cohort Study*, 74(2) J. Am. Med. Ass'n Psychiatry 169-78 (2017).

generally very certain about their decision prior to arriving at a clinic,[35] and waiting periods and forced in-person counseling visits do not improve patient decision-making or serve patients in any other way.[36] Rather, they impose tremendous burdens on patients forcing them to disclose that they are seeking abortion to bosses, coworkers, men involved in the pregnancies, family members, friends and child care providers.[37]

14. To the extent performing an ultrasound is medically relevant to a medication abortion, it would be so at or close to the time the patient takes the medication, not 3 days in advance. As I discussed in my original affidavit, however, high quality research shows that medication abortion can be safely administered via telemedicine to eligible patients.[38]

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[35] Lauren J. Ralph, et al., *Measuring Decisional Certainty Among Women Seeking Abortion*, 95(3) Contraception 269-78 (2017), *available at* https://pubmed.ncbi.nlm.nih.gov/27745910/.

[36] Sarah C. M. Roberts, et al., *Utah's 72-Hour Waiting Period for Abortion: Experiences Among a Clinic-Based Sample of Women*, 48(4) Persp. on Sexual and Reprod. Health 179-87 (2016), *available at* https://pubmed.ncbi.nlm.nih.gov/27010515/; Corinne H. Rocca, et al., *Emotions and Decision Rightness Over Five Years Following an Abortion: An Examination Of Decision Difficulty and Abortion Stigma*, 248 Soc. Sci. & Med. 112704 (2020), *available at* https://www.sciencedirect.com/science/article/pii/S0277953619306999 (95% of patients report their abortion was the right decision for them); Ariana Eunjing Cha, *Five Years After an Abortion, Most Women Say They Made the Right Decision*, Washington Post (Jan. 12, 2020), *available at* https://www.washingtonpost.com/health/2020/01/12/five-years-after-an-abortion-most-women-say-they-made-right-decision/.

[37] Roberts, et al., *supra* n.36.

[38] Erica Chong, et al., *Expansion of a Direct-to-Patient Telemedicine Abortion Service in the United States and Experience during the COVID-19 Pandemic*, 104(1) Contraception 43-48 (2021), *available at* https://www.sciencedirect.com/science/article/abs/pii/S0010782421000913; Ushma D. Upadhyay, et al., *Safety And Efficacy Of Telehealth Medication Abortions In The Us During The Covid-19 Pandemic*, 4(8) JAMA Network Open 1-3 (2021), *available at* https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2783451.

DATED: 9/29/21

Ushma Upadhyay, Ph.D., M.P.H.

**CALIFORNIA JURAT WITH AFFIANT STATEMENT** **GOVERNMENT CODE § 8202**

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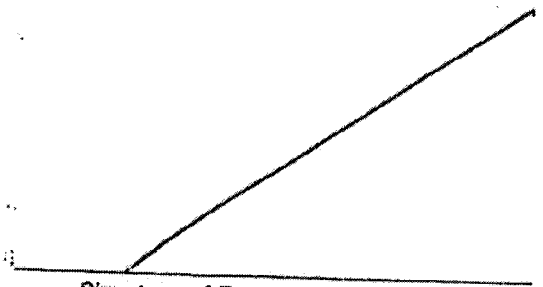

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State of California
County of Contra Costa

Subscribed and sworn to (or affirmed) before me on this 29th day of September, 2021
by (1) Ushma Upadhyay
(and (2) ),
*Name(s) of Signer(s)*

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

KATE COOPER HERZOG
Notary Public - California
Contra Costa County
Commission # 2306817
My Comm. Expires Oct 23, 2023

Signature _____
*Signature of Notary Public*

*Seal*
*Place Notary Seal Above*

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Number of Pages: 11 Signer(s) Other Than Named Above: _____

**IN THE DISTRICT COURT OF OKLAHOMA COUNTY**
**STATE OF OKLAHOMA**

OKLAHOMA CALL FOR REPRODUCTIVE JUSTICE, on behalf of itself and its members; TULSA WOMEN'S REPRODUCTIVE CLINIC, LLC, on behalf of itself, its physicians, its staff, and its patients; ALAN BRAID, M.D., on behalf of himself and his patients; COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, INC., on behalf of itself, its physicians, its staff, and its patients; and PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, on behalf of itself, its physicians, its staff, and its patients,

Plaintiffs,

v.

JOHN O'CONNOR, in his official capacity as Attorney General for the State of Oklahoma; DAVID PRATER, in his official capacity as District Attorney for Oklahoma County; STEVE KUNZWEILER, in his official capacity as District Attorney for Tulsa County; LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; KATIE TEMPLETON, in her official capacity as President of the Oklahoma State Board of Osteopathic Examiners; LANCE FRYE, in his official capacity as the Commissioner of the Oklahoma State Board of Health; and JUSTIN WILSON, in his official capacity as the President of the Oklahoma State Board of Pharmacy; as well as their employees, agents, and successors,

Defendants.

Case No. CV-2021-2072
Hon. C. Truong

**REBUTTAL AFFIDAVIT OF JOEY BANKS, M.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY INJUNCTION**

Dr. Joey Banks declares and states the following:

1. I previously submitted an affidavit in support of Plaintiffs' motion for a temporary injunction in this case. All of the information in that document remains true and correct. I submit

this supplemental affidavit to respond to some of the statements made by the affiants Ingrid Skop, M.D., and Tabitha Danley, D.O., about the OB/GYN requirement. The fact that I do not respond to a particular statement therein does not mean that I agree with it.

2. Dr. Skop and Dr. Danley suggest that board-certified OB/GYNs are the best qualified to provide abortion care. As explained more fully below, their basis for this opinion is that OB/GYNs receive certain training and education during residency, but Dr. Skop herself acknowledges that "not all board-certified [OB/GYNs] have received specific training performing abortions." Skop Aff. ¶ 19; *see also* Danley Aff. ¶¶ 5-6. Regardless of specialty, board-certification cannot substitute for specific training and experience in abortion care, and, even if it could, that would not detract from the fact that "clinicians in many specialties can provide safe abortion services," as the professional association for OBGYNs itself has recognized.[1] My years of experience providing abortion care; working with other abortion providers; and training other clinicians to provide abortion care, including family medicine physicians, also bears this out. Banks Aff. ¶¶ 14-20.

3. More specifically, Dr. Skop and Dr. Danley suggest that board-certified OB/GYNs are the best qualified to provide abortion care because they learn dilatation and curettage procedures (D&C) and are more familiar with reproductive health care and complications. Skop Aff. ¶ 19; *see also* Danley Aff. ¶¶ 5-6. However, as I discussed in my earlier affidavit, abortion care is a form of healthcare that spans several specialties. Reflecting this, Dr. Danley herself completed a fellowship in obstetrics and has focused her career on "family medicine[] [and] obstetrical and prenatal care" in Oklahoma, and concedes that "D&C

[1] ACOG, Comm. on Health Care for Underserved Women, *Committee Opinion No. 815, Increasing Access to Abortion* 136(6) Obstetrics & Gynecology e107-15 (Dec. 2020) (replaces Committee Opinion No. 613, Nov. 2014) ("ACOG Comm. Op. 815"), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2020/12/increasing-access-to-abortion.pdf.

and D&E [dilation and evacuation] . . . are procedures that a Family Medicine doctor could learn through" training during or after residency. Danley Aff. ¶¶ 1, 6. Moreover, as I discussed in my earlier affidavit, family medicine physicians have unique strengths when it comes to providing abortion care, as this specialty emphasizes comprehensive and holistic health care for the patient and her family. Banks Aff. ¶ 22. Dr. Skop also references an article that reported a positive association between board-certification and clinical outcomes generally. Skop Aff. ¶ 21 n.33. But that article does not address abortion and is irrelevant to the question of whether requiring board-certification as an OB/GYN specifically has any benefit.

4. As I previously stated, abortion-related complications are very rare, and abortion providers, regardless of their specialty, are competent to determine the need for a referral if the patient develops a health condition that they are unable to treat. Banks Aff. ¶¶ 15, 25, 26.[2]

5. Dr. Skop speculates that OB/GYNs provide more abortions, although she states that she is "unsure of the specific numbers." Skop Aff. ¶ 19. But, this is plainly incorrect in Oklahoma. The most recent numbers paint a clear picture: over half of the abortion providers at the only four clinics in Oklahoma are board-certified as family medicine physicians or in another non-OB/GYN specialty. Banks Aff. ¶ 13.[3]

6. Dr. Skop suggests that the OB/GYN Requirement will not significantly reduce access to the number of qualified providers in Oklahoma because there are 43,000 board-certified OB/GYNs in the *United States*, but this ignores the acute shortage of OB/GYNs faced

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[2] *See also* Nat'l Acads. Of Scis., Eng'g., & Med. *The Safety and Quality of Abortion Care in the United States*, at 105 (2018), http://nap.edu/24950 (reviewing studies of the safety of abortion care as conducted by family medicine practitioners and finding that "[a]ll complications were minor and managed effectively at rates similar to those in OB/GYN practices and specialty abortion clinics").

[3] I understand from counsel that six of the ten physicians at Planned Parenthood's clinics are board-certified family medicine physicians. I am also aware that "four out of eight doctors licensed to work at Trust Women"—the only other clinic in Oklahoma—are not board-certified OB/GYNs and thus would be unable to provide abortion care if the OB/GYN Requirement takes effect. Sabrina Tavernise, *With Abortion Largely Banned in Texas an Oklahoma Clinic is Inundated*, N.Y. Times (Sept. 26, 2021), https://www.nytimes.com/2021/09/26/us/oklahoma-abortion.html.

by Oklahoma and other rural states, as I discussed in my earlier affidavit. Skop Aff. ¶ 20. Although Dr. Skop questions without basis whether harassment and stigma contribute to the shortage of abortion providers, that is completely out of line with my personal experience as an abortion provider who has tried to hire others. *Id.*

7. Additionally, Dr. Skop and Dr. Danley do not even attempt to explain why a board-certified OB/GYN would be better equipped to provide the most common form of abortion in Oklahoma—medication abortion (or abortion by pills)—which does not involve a procedure at all. As I previously stated, family medicine physicians routinely prescribe medications that are comparable to or risker than medication abortion, such as antibiotics or pain medications like fentanyl. Banks Aff. ¶ 24. And many family medicine doctors provide miscarriage management, which is typically similar to abortion care. *Id.*

8. It appears that Dr. Skop doesn't actually contend that board-certified OB/GYNs are the best qualified to become abortion providers, because she ultimately asserts that the issue is not "whether other physicians can be trained to perform abortions," but rather whether Oklahoma "in the interest of protecting the women who seek this elective procedure . . . may mandate that the procedure be performed" by board-certified OB/GYNs. Skop Aff. ¶ 21. The same goes for Dr. Danley, who "offer[s] no opinion, at this juncture, on the law itself." Danley Aff. ¶ 4. For all the reasons above and that I stated previously, in my expert opinion, as a family medicine physician who has provided abortion for decades and trained many clinicians in providing this care, this requirement has no medical basis. But, it will cause harm to the health of Oklahomans seeking abortion care because it will significantly reduce the number of qualified providers, and thus access to high quality, safe abortion care, in Oklahoma.

Dated this 28 day of Sept., 2021.

Joey Banks, M.D.

NOTARY

SUNDI JO HAMILTON
NOTARY PUBLIC for the
State of Montana
Residing at Missoula, MT
My Commission Expires
November 08, 2024.

Sundi J. Hamilton