STATE OF MICHIGAN
IN THE COURT OF CLAIMS

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

Plaintiffs,

v

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

Defendant.
_______________________________________ /

Case No.

Hon.

BRIEF IN SUPPORT OF PLAINTIFFS' APRIL 7, 2022 MOTION FOR PRELIMINARY INJUNCTION

ORAL ARGUMENT REQUESTED

DEBORAH LaBELLE (P31595)
221 N. Main St., Ste. 300
Ann Arbor, MI 48104
(734) 996-5620
deblabelle@aol.com

MARK BREWER (P35661)
17000 W. 10 Mile Rd.
Southfield, MI 48075
(248) 483-5000
mbrewer@goodmanacker.com

HANNAH SWANSON*
Planned Parenthood Federation of America
1110 Vermont Ave. NW, Ste. 300
Washington, DC 20005
(202) 803-4030
hannah.swanson@ppfa.org

SUSAN LAMBIASE*
Planned Parenthood Federation of America
123 William St., 9th Floor
New York, NY 10038
(212) 261-4405
susan.lambiase@ppfa.org

BONSITU KITABA-GAVIGLIO (P78822)
DANIEL S. KOROBKIN (P72842)
American Civil Liberties Union Fund of Michigan
2966 Woodward Ave.
Detroit, MI 48201
(313) 578-6800
bkitaba@aclumich.org
dkorobkin@aclumich.org

MICHAEL J. STEINBERG (P43085)
RUBY EMBERLING**
AUDREY HERTZBERG**
HANNAH SHILLING**
Civil Rights Litigation Initiative
University of Michigan Law School
701 S. State St., Ste. 2020
Ann Arbor, MI 48109
(734) 763-1983
mjsteinb@umich.edu

**Pro hac vice application forthcoming*
***Student attorney practicing pursuant to MCR 8.120*

ATTORNEYS FOR PLAINTIFFS

TABLE OF CONTENTS

INTRODUCTION 1

BACKGROUND AND FACTS 2

Plaintiffs 2

Defendant 4

Legal Background 5

Facts Relating to Pregnancy 8

Facts Relating to Abortion 9

The Criminal Abortion Ban Risks Imminent Harm to Plaintiffs and Their Patients 11

ARGUMENT 14

I. Plaintiffs Are Likely to Prevail on Their Claim That the Criminal Abortion Ban Is Unconstitutional 15

A. The Criminal Abortion Ban Is Unconstitutionally Vague 15

B. The Criminal Abortion Ban Violates Rights Protected by the Michigan Constitution 19

1. The Criminal Abortion Ban Violates the State Right to Bodily Integrity 21

2. The Criminal Abortion Ban Violates State Equal Protection Guarantees 25

3. The Criminal Abortion Ban Violates ELCRA 29

4. The Criminal Abortion Ban Violates the State Constitutional Rights to Privacy and Liberty Under the Retained Rights Clause 31

5. The State Due Process Right to Liberty and Privacy Protects the Right to Abortion 34

II. Plaintiffs Will Suffer Irreparable Harm Without an Injunction 37

III. An Injunction Will Not Injure Defendant 38

IV. The Public Interest Is Served and Not Harmed by an Injunction 38

CONCLUSION 39

INTRODUCTION

A 1931 Michigan statute bans abortion, even in cases of rape, incest, or grave threats to the pregnant person's health. Under this law, providing an abortion at any point in pregnancy is punishable as a felony, unless the abortion is necessary to save the pregnant person's life. MCL 750.14 (the "Criminal Abortion Ban"). No injunction currently bars this statute's enforcement.

In *People v Bricker*, 389 Mich 524, 527–528, 531; 208 NW2d 172 (1973), the Michigan Supreme Court construed the Criminal Abortion Ban to be enforceable only as allowed by *Roe v Wade*, 410 US 113; 93 S Ct 705; 35 L Ed 2d 147 (1973). The Court held that, under *Roe*, the Criminal Abortion Ban did not apply to abortions before viability, or after viability where necessary to preserve the patient's life or health. *Bricker*, 389 Mich at 529–530.

But federal case law interpreting *Roe* has changed over time, and *Roe* itself now faces a direct challenge before the United States Supreme Court, leaving not only its contours but perhaps its very existence open to question. See *Dobbs v Jackson Women's Health Org*, ___ US ___; 141 S Ct 2619; 209 L Ed 2d 748 (2021) (mem) (granting certiorari). Because the Criminal Abortion Ban has been construed as incorporating this shifting federal doctrine, it is unclear today what the law precisely allows.

It is clear, however, that the Criminal Abortion Ban *as written* is blatantly unconstitutional. If the Criminal Abortion Ban were enforced against physicians who provide abortion in Michigan, Planned Parenthood of Michigan (PPMI) and its Chief Medical Officer, Sarah Wallett, M.D., M.P.H., FACOG (together, "Plaintiffs"), would be forced to stop providing abortions. People in Michigan would be unable to access abortion under virtually any circumstance. Accordingly, Plaintiffs bring this case, on behalf of themselves and their patients, to establish the Criminal Abortion Ban's unconstitutionality as a matter of Michigan law. The Criminal Abortion Ban is unconstitutionally vague, and it violates the rights to liberty and privacy, bodily integrity, and

equal protection guaranteed by the 1963 Michigan Constitution and the Elliott-Larsen Civil Rights Act (ELCRA).

Plaintiffs seek a preliminary injunction pursuant to MCR 3.310 to maintain the legal status quo that allows people to access abortion in this state. Specifically, the Court should enter a preliminary injunction, consistent with *Bricker*, prohibiting enforcement of the Criminal Abortion Ban and any other Michigan statute or regulation to the extent that it prohibits abortions authorized by a licensed physician before viability, or after viability when necessary in the physician's judgment to preserve the life or health of the pregnant person. See *Bricker*, 389 Mich at 529–530. Doing so during the pendency of this case is consistent with the Michigan Supreme Court's construction of the Criminal Abortion Ban in *Bricker*, which has protected access to abortion in Michigan since 1973. Absent injunctive relief, Plaintiffs and their patients risk imminent and irreparable harm.

BACKGROUND AND FACTS

Plaintiffs

Plaintiffs have devoted their lives and livelihoods to ensuring access to reproductive health care in Michigan. For about 100 years, PPMI or its predecessors has provided a wide range of this care to patients in this state. Exhibit 1, Affidavit of Sarah Wallett, M.D., M.P.H., FACOG, in Support of Plaintiffs' April 7, 2022 Motion for Preliminary Injunction ("Wallett Aff") ¶¶ 11–12. These services include testing and treatment for sexually transmitted infections, contraception counseling and provision, HIV prevention services, pregnancy testing and options counseling, preconception counseling, gynecologic services including well-person exams, cancer screening, miscarriage management, and abortion. *Id.* ¶ 12. PPMI employs staff and operates 14 health centers across Michigan. *Id*. ¶¶ 11, 18.

In Fiscal Year 2020, PPMI provided 8,448 abortions. *Id.* ¶ 13. Of those, 6,626 were early

medication abortions (i.e., using medications alone), and 1,822 were procedural abortions.[1] *Id.* At PPMI, between July 2020 and June 2021, 27% of abortion patients had incomes below 101% of the federal poverty level, and an additional 22% had incomes between 100% and 200% of the federal poverty level.[2] *Id.* ¶ 51. The vast majority—93%—of PPMI abortion patients between July 2020 and June 2021 paid for their abortions out of pocket rather than with insurance. *Id.*

PPMI faces possible felony criminal prosecution and licensure penalties for violating the Criminal Abortion Ban, as well as possible actions to enjoin operation of their licensed health centers. See MCL 750.14; MCL 333.20199(1); MCL 333.20165; MCL 333.20168(1); MCL 333.20177; see also MCL 750.10; MCL 333.20109, citing MCL 333.1106. PPMI brings this suit on its own behalf, and on behalf of its physicians, staff, and patients who seek abortions.

Sarah Wallett, M.D., M.P.H., FACOG, is a board-certified obstetrician-gynecologist licensed to practice medicine in Michigan. Wallett Aff ¶ 1. Dr. Wallett has been the Chief Medical Officer of PPMI since March 2019. *Id.* ¶ 9. She is also an adjunct clinical assistant professor at the University of Michigan Medical School in Ann Arbor. *Id.* Dr. Wallett provides abortion to people in Michigan. *Id.* ¶ 2. Dr. Wallett thus faces possible felony criminal prosecution and potential licensure penalties for violating the Criminal Abortion Ban. See *id.* ¶¶ 1, 3–4, 73, 75. Dr. Wallett brings this suit on her own behalf and on behalf of her patients who seek abortions.[3]

---

[1] In 2020, the most recent year for which statistics are currently available, 29,669 abortions were performed in Michigan. Wallett Aff ¶ 42.

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

[3] Plaintiffs' third-party standing to assert claims on their patients' behalf is consistent with longstanding Michigan law. *People v Rocha*, 110 Mich App 1, 17; 312 NW2d 657 (1981) (permitting jus tertii standing to argue the constitutional rights of a third party impacted by a statute where a substantive relationship such as doctor/patient exists); *cf June Med Servs LLC v Russo*, ___ US ___; 140 S Ct 2103, 2118; 207 L Ed 2d 566 (2020) (plurality opinion) (recognizing that the United States Supreme Court has "long permitted abortion providers to invoke the rights of their actual or potential patients in challeng[ing] abortion [laws]").

PPMI and Dr. Wallett provide abortion in reliance on the Michigan Supreme Court's ruling construing the Criminal Abortion Ban as not prohibiting abortions that are constitutionally protected under *Roe.* They wish to continue to provide abortions, *id.* ¶¶ 88, 91, consistent with the Court's longstanding interpretation of the Criminal Abortion Ban. But they will be unable to do so if it would place them at risk of arrest, criminal prosecution, *id.* ¶¶ 75, 88, 91, and licensure revocation, *id.* ¶¶ 3, 13, 73. In turn, their patients will be unable to obtain the abortions they seek in Michigan—or at all, *id*. ¶¶ 75–85, putting them at increased risk of physical, mental, and financial harm, *id.* ¶¶ 19–41, 79–86.

Defendant

The Attorney General of the State of Michigan is the top law enforcement official in the state, charged with defending and enforcing the proper laws in the state, as well as supervising all county prosecutors charged with enforcing the criminal statutes of Michigan. MCL 14.28–14.30; Const 1963, art 5, §§ 1, 3. The Attorney General also acts in a representative and advisory capacity with respect to Michigan administrative agencies, including the Michigan Department of Licensing and Regulatory Affairs (LARA), which can impose penalties on Michigan-licensed health care facilities and physicians. See MCL 333.16221(b)(v); MCL 333.16226(1); MCL 333.20165; MCL 333.20168(1); MCL 333.20177; MCL 333.20199(1). Indeed, "it is universally recognized that among the primary missions of a state attorney general is the duty to give legal advice . . . to . . . agencies of state government." *Sch Dist of City of East Grand Rapids, Kent Co v Kent Co Tax Allocation Bd*, 415 Mich 381, 394; 330 NW2d 7 (1982). The Attorney General is the appropriate defendant in a suit over the constitutionality of the Criminal Abortion Ban. See, e.g., *Mahaffey v Attorney General,* 222 Mich App 325; 564 NW2d 104 (1997) (suit against Michigan Attorney General in case challenging constitutionality of Michigan abortion regulation). The Attorney General is sued in her official capacity.

Legal Background

The Criminal Abortion Ban provides in relevant part: "Any person who shall wilfully administer to any pregnant woman any medicine, drug, substance or thing whatever, or shall employ any instrument or other means whatever, with intent thereby to procure the miscarriage of any such woman, unless the same shall have been necessary to preserve the life of such woman, shall be guilty of a felony . . . . " MCL 750.14.

Violating the Ban is an unclassified felony, punishable by up to four years' imprisonment, a fine of up to $5,000, or both. MCL 750.503. Physicians convicted of violating the Criminal Abortion Ban may also face administrative penalties from LARA, MCL 333.20104(4), including permanent license revocation, MCL 333.16221(b)(v); MCL 333.16226(1). Michigan-licensed health care facilities that employ physicians who violate the Criminal Abortion Ban may face possible penalties as well, including criminal prosecution, see MCL 333.20199(1); see also MCL 750.10, license revocation through administrative enforcement by LARA, see MCL 333.20165; MCL 333.20168(1); see also MCL 333.20109, citing MCL 333.1106, or actions to enjoin operation of their licensed facilities, MCL 333.20177.

While the Criminal Abortion Ban's constitutionality has been challenged before, the Michigan Supreme Court has not addressed those claims, choosing instead to construe the Ban consistent with *Roe*'s holding that the United States Constitution bars states from prohibiting abortion before viability, or after viability where necessary to save the patient's life or health. *Bricker*, 389 Mich at 529–531. Specifically, *Bricker* held that the Criminal Abortion Ban "shall not apply to 'miscarriages' authorized by a pregnant woman's attending physician in the exercise of his medical judgment; the effectuation of the decision to abort is also left to the physician's judgment; however, a physician may not cause a miscarriage after viability except where necessary, in his medical judgment to preserve the life or health of the mother. . . . [E]xcept as to

those cases defined and exempted under *Roe v. Wade* . . . , criminal responsibility attaches." *Id*. at 530–531. The Michigan Supreme Court's saving construction thus depends entirely on *Roe*. See *id.* PPMI has relied on and operated under this construction of the Criminal Abortion Ban since 1973. See Wallett Aff ¶¶ 3–4, 11. Because *Bricker* arose as a criminal appeal, the Court in *Bricker* did not enter an injunction reflecting this construction.

Accordingly, under *Bricker*, the legality of abortion has been tied to federal law. The contours of federal law have changed in the decades since *Roe* and *Bricker* were decided, leaving Michigan abortion providers and their patients at risk of state officials attempting new interpretations of the ban. This risk is exacerbated by the United States Supreme Court imminently deciding the question whether *Roe v Wade* should be overruled. See Brief for Petitioners at i, *Dobbs v Jackson Women's Health Org*, 2021 WL 3145936 (US, July 22, 2021) (Docket No. 19-1392); see also *id.* at 14 ("This Court should overrule *Roe* and *Casey*."); *Dobbs v Jackson Women's Health Org*, ___ US ___; 141 S Ct 2619; 209 L Ed 2d 748 (2021) (mem) (granting certiorari). *Dobbs*, argued on December 1, 2021, is already disrupting access to abortion despite nearly fifty years of United States Supreme Court precedent protecting this right.[4] Indeed, it appears

[4] See Zernike, *States Aren't Waiting for the Supreme Court to Tighten Abortion Laws*, NY Times (March 7, 2022) <https://www.nytimes.com/2022/03/07/us/abortion-supreme-court- roe-v-wade.html> (accessed April 4, 2022). On December 10, 2021, in *United States v Texas*, ___ US ___; 142 S Ct 522; 211 L Ed 2d 349 (2021) (per curiam) (mem), the Supreme Court denied the United States's request to enjoin Texas's ban on abortions after six weeks of pregnancy, known as S.B. 8, in direct contravention of *Roe*, 410 US at 164–165, and *Planned Parenthood of Southeastern Pa v Casey*, 505 US 833, 846; 112 S Ct 2791; 120 L Ed 2d 674 (1992), such that the clearly unconstitutional ban has been in effect for more than seven months. The Oklahoma State Legislature is considering two pieces of S.B. 8-style legislation to effectively ban abortion: Senate Bill 1503, which has passed the Oklahoma Senate, see Okla Senate Bill 1503, Reg Sess (2022), and House Bill 4327, which has passed the Oklahoma House, see Okla House Bill 4327, Reg Sess (2022). On October 20, 2021, a so-called "heartbeat" bill was introduced in the Michigan House of Representatives and referred to the Committee on Health Policy. See Mich House Bill 5444, § 6, 101st Leg, Reg Sess (2021) ("HB 5444"); Zivian et al, *'Heartbeat' Abortion Bill Raises Tensions in Michigan*, Mich State Univ Sch of Journalism (December 16, 2021) <https://news.

increasingly likely that *Roe* will either be overruled or its protections severely curtailed,[5] leaving it to state courts to interpret abortion bans in the context of individuals' state constitutional rights.

In Michigan, public officials have added to the confusion by publicly asserting that the Criminal Abortion Ban will become fully enforceable, allowing for arrests and prosecutions, upon the Supreme Court issuing its ruling in *Dobbs*.[6]

While the full consequences of the United States Supreme Court's decision in *Dobbs* cannot be known with certainty until the Court issues its opinion—as it could do any day now—there is little doubt that the Michigan Supreme Court's only existing interpretation of the Criminal Abortion Ban lacks the clarity needed to guide providers, patients, and state actors at a time when the protections of *Roe* have been called into question and may even be extinguished. The Michigan Supreme Court has thus far not addressed whether the Criminal Abortion Ban is void for vagueness, or whether it violates other rights guaranteed by the Michigan Constitution. Because the Criminal Abortion Ban has not been enjoined, nothing prevents overzealous prosecutors from capitalizing on this uncertainty and attempting to enforce the Criminal Abortion Ban the minute a decision in *Dobbs* is announced. Plaintiffs risk criminal prosecution and more, and their patients seeking abortion risk being forced to attempt to travel hundreds of miles for care—which for many

---

jrn.msu.edu/2021/12/heartbeat-abortion-bill-raises-tensions-in-michigan/> (accessed April 4, 2022). The bill would make abortions illegal after a fetal "heartbeat" is detected, at approximately six weeks of pregnancy. HB 5444, § 6; Zivian, *supra* note 4.

[5] See Liptak, *Supreme Court Seems Poised to Uphold Mississippi's Abortion Law*, NY Times (December 1, 2021) <https://www.nytimes.com/2021/12/01/us/politics/supreme-court-mississippi-abortion-law.html> (accessed April 4, 2022).

[6] Oosting, *A Michigan Abortion Ban Could 'Shock' State Politics Ahead of 2022 Election*, Bridge Mich (February 22, 2022) <https://www.bridgemi.com/michigan-government/ michigan-abortion-ban-could-shock-state-politics-ahead-2022-election> (accessed April 4, 2022). Three declared candidates for Attorney General in Michigan have asserted they would enforce the Criminal Abortion Ban in Michigan upon a ruling in *Dobbs* abrogating *Roe*. *Id.*

will not be possible, forcing them to carry their pregnancy to term and give birth against their will. By contrast, a preliminary injunction maintaining the status quo would allow Plaintiffs to continue to provide abortion to their patients until the scope and constitutionality of the Criminal Abortion Ban can finally be determined as a matter of Michigan law.

Facts Relating to Pregnancy

The decision whether to become or remain pregnant is one of the most personal and consequential a person will make in their lifetime, Wallett Aff ¶ 41; see also *id.* ¶¶ 19–40, and people experience their pregnancies in a range of different ways, *id.* ¶ 20. While pregnancy can be a celebratory and joyful event for many, even an uncomplicated pregnancy challenges a person's entire physiology. *Id.*; see also *id.* ¶¶ 23–28, 31–32, 39. Pregnancy can also be a period of physical and personal discomfort or even alienation, *id.* ¶ 20; some pregnant people experience significant mental health challenges, *id.* ¶¶ 20, 31, 39.

Pregnancy also carries significant medical risk, *id.* ¶¶ 21–31, as does childbirth, *id.* ¶¶ 32–34. Women of color, and Black women in particular, face heightened risks of maternal mortality and pregnancy-related complications compared to non-Hispanic white women. *Id.* ¶ 22; see also *id.* ¶ 82. This disparity has been exacerbated in the past year. *Id.* A woman's risk of death associated with childbirth, specifically, is more than 12 times higher than that associated with abortion, and the total risk of maternal mortality is 34 times higher than the risk of death associated with abortion. *Id.* ¶ 42. Every pregnancy-related complication is more common among women having live births than among those having abortions. *Id.*

Separate from pregnancy, childbirth itself is a significant medical event. *Id.* ¶ 32; see also *id.* ¶ 42. Even a normal pregnancy can suddenly become life-threatening during labor and delivery. *Id.* ¶ 32. Pregnant people may also face an increased risk of intimate partner violence. *Id.* ¶ 38. Women who have experienced intimate partner violence and who give birth after being unable to

access a desired abortion will, in many cases, face increased difficulty escaping that relationship. *Id.*; see also *id.* ¶ 53. And pregnancy, childbirth, and raising a child can have long-term impacts on a person's financial security. *Id.* ¶¶ 37, 80 & n 77, 81; see also *id.* ¶ 52.

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

Facts Relating to Abortion

Abortion is one of the safest and most common medical services performed in the United States today. *Id.* ¶ 42. Indeed, legal abortion carries far fewer risks than childbirth. *Id.* ¶ 42; compare *id.* ¶¶ 19–41, with *id.* ¶¶ 43–58, 80–81. Approximately one in four women in this country will have an abortion by age forty-five. *Id.* ¶ 42.

There are two general types of abortion: medication abortion and procedural abortion. *Id.* ¶ 43. For early medication abortion, patients take a regimen of two prescription drugs approved by the United States Food and Drug Administration. *Id.* ¶ 44. Patients take the first medication, mifepristone, then 0 to 48 hours later, they take the second medication, misoprostol, at a location of their choosing, typically at home. *Id.* Together, the medications cause the pregnancy to pass in a process similar to miscarriage. *Id.* This regimen is evidence-based and widely used to terminate pregnancies through 11 weeks of pregnancy, as measured from the first day of the patient's last menstrual period (LMP). *Id.* ¶ 45. Through 11 weeks LMP, patients wishing to terminate their pregnancies may choose between medication and procedural abortion. *Id.* After 11 weeks LMP, only procedural abortion is available. *Id.*

For procedural abortion, a clinician uses instruments and/or medication to widen the patient's cervical opening and to evacuate the contents of the uterus. *Id.* ¶ 46. Procedural abortion

is a straightforward and brief procedure. *Id.* It is almost always performed in an outpatient setting and may at times involve local anesthesia or conscious sedation to make the patient more comfortable. *Id.* Although procedural abortion is sometimes referred to as "surgical abortion," it is not what is commonly understood to be surgery, as it involves no incisions, no need for general anesthesia, and no need for a sterile field. *Id.* Up to approximately 14 weeks LMP, procedural abortion relies on the aspiration technique. *Id.* ¶ 47. After that point, procedural abortion involves the dilation and evacuation technique. *Id.* Starting around 18 to 20 weeks LMP, an additional procedure may be performed to ensure that the patient's cervix is adequately dilated for the procedural abortion. *Id.* This may occur on the same day as the abortion, or the day prior to the abortion. *Id.*

PPMI's Ann Arbor East and Kalamazoo health centers provide procedural abortion through 19 weeks, 6 days LMP, and its Flint health center provides procedural abortion through 16 weeks, 6 days LMP. *Id.* ¶ 13. All 14 of PPMI's health centers provide medication abortion. *Id*. ¶¶ 11, 13.

There is no typical abortion patient, and pregnant people seek abortions for a variety of deeply personal reasons. *Id.* ¶¶ 49, 58; see also *id.* ¶¶ 52–57. In addition to cisgender women, gender-nonconforming people, transmasculine people, and trans men have abortions. *Id.* ¶ 49. Nearly 60% of abortion patients nationally already have at least one child. *Id.* ¶ 50. Some people have abortions because they conclude that it is not the right time in their lives to have a child or to add to their families. *Id.* ¶¶ 49–50. Some decide to have an abortion because they do not want children at all. *Id.* ¶ 49. Some people seek abortions because they are experiencing intimate partner violence and fear that carrying the pregnancy to term and giving birth would further tie them to their abusers. *Id.* ¶ 53. Some people seek abortions because the pregnancy is the result of rape. *Id.* ¶ 54. Some people decide to have an abortion because of an indication or diagnosis of a fetal

medical condition, including diagnoses that mean after delivery the baby would never be healthy enough to go home. *Id.* ¶ 56. While some may decide to carry such a pregnancy through delivery, others may decide that they wish to terminate the pregnancy. *Id.* Some abortion patients experience pregnancy complications that lead them to end their pregnancies to preserve their own life or health. *Id.* ¶ 57.

The decision to terminate a pregnancy is often motivated by a combination of complex and interrelated factors that are intimately tied to the pregnant person's identity and values, mental and physical health, family circumstances, resources, and economic stability. *Id*. ¶ 58.

The Criminal Abortion Ban Risks Imminent Harm to Plaintiffs and Their Patients

If the Criminal Abortion Ban were enforced, Plaintiffs would be forced to stop offering virtually all abortions—that, or face felony prosecution, *id.* ¶ 75, and more, *id.* ¶¶ 3, 13, 73.[7] The Ban would thus have devastating consequences for Plaintiffs and their patients. See *id.* ¶¶ 75–85. Many people would not be able to travel to another state to access abortion, or would be significantly delayed by the cost and logistical arrangements required to do so. *Id.* ¶ 76.

Delays in accessing abortion, or being unable to access abortion at all, pose risks to people's health. *Id.* ¶ 79. While abortion is very safe at any point in pregnancy, risks increase with gestational age. *Id.* And because pregnancy and childbirth are far more medically risky than abortion, forcing people to carry a pregnancy to term exposes them to an increased risk of physical harm. *Id.*; see also *id.* ¶¶ 19–42. Further, a person's ability to access abortion has consequences not only for that person, but also for their family and community. *Id.* ¶ 80.

Enforcing the Criminal Abortion Ban as written would most harm people who are poor or

[7] Enforcement of any other Michigan statute or regulation to prohibit abortion provided by a licensed physician would have the same effect. PPMI and Dr. Wallett therefore seek preliminary injunctive relief against all such enforcement.

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

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

If abortion is criminalized in Michigan, some people will likely self-manage abortion. *Id.* ¶ 84. Some who do may experience one of the rare complications from medication abortion and may be too afraid to seek necessary follow-up care. *Id.* This could cause serious harm—not because abortion is unsafe, but because the Criminal Abortion Ban has made it unsafe for them to be fully open with their medical providers. *Id.*

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

The Criminal Abortion Ban would also directly harm PPMI's mission and its standing in the eyes of its patients. *Id.* ¶ 89. Some patients might misunderstand why PPMI is no longer providing abortion and think that it is because its providers no longer want to help them. *Id.* PPMI would no longer be seen as a safe place where people can be open and honest about their health

care histories and needs, not only harming PPMI's reputation as a health care provider, but interfering with its ability to provide other care. *Id.*

Additionally, some PPMI staff may be afraid to continue working at PPMI if the Criminal Abortion Ban were enforced. *Id.* ¶ 90. Given the statute's vagueness, even if PPMI and its staff complied with the Ban, a prosecutor might accuse staff of violating it. *Id.* Some staff might prefer to leave PPMI given this risk. *Id.* Other staff might simply be unable to bear turning patients away. *Id.*

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

Uncertainty about when or whether the Criminal Abortion Ban might become enforceable as written interferes with PPMI's and Dr. Wallett's ability to plan for the months ahead, because they do not know whether they will still be able to provide abortion weeks or months from now. *Id*. ¶ 92.

Unless this Court maintains the status quo and enjoins enforcement of the Criminal Abortion Ban to continue to allow abortions before viability, and after viability where necessary to preserve the patient's life or health, those risks will continue to threaten access to abortion in Michigan.

ARGUMENT

Under *Bricker*, pre-viability abortion, and post-viability abortion when necessary to preserve the patient's life or health, are permitted under the Criminal Abortion Ban. A preliminary injunction maintaining this status quo is necessary to protect Plaintiffs from prosecution during the pendency of this litigation, and to ensure that patients seeking abortion continue to have access to this constitutionally protected health care. "The purpose of a preliminary injunction is to preserve the 'status quo pending a final hearing regarding the parties' rights.'" *Hammel v Speaker of the House of Reps*, 297 Mich App 641, 647–648; 825 NW2d 616 (2012), quoting *Mich AFSCME Council 25 v Woodhaven-Brownstone Sch Dist*, 293 Mich App 143, 145; 809 NW2d 444 (2011); see also *Fancy v Egrin*, 177 Mich App 714, 719; 442 NW2d 765 (1989).

Four factors determine whether a court should issue a preliminary injunction: "(1) the likelihood that the party seeking the injunction will prevail on the merits, (2) the danger that the party seeking the injunction will suffer irreparable injury if the injunction is not issued, (3) the risk that the party seeking the injunction would be harmed more by the absence of an injunction than the opposing party would be by the granting of the relief, and (4) the harm to the public interest if the injunction is issued." *Fruehauf Trailer Corp v Hagelthorn*, 208 Mich App 447, 449; 528 NW2d 778 (1995). In evaluating these factors, the court "balance[s] the benefit of an injunction to [the] plaintiff against the inconvenience and damage to [the] defendant, and grants an injunction . . . as seems most consistent with justice and equity under all the circumstances of the case." *Kernen v Homestead Dev Co*, 232 Mich App 503, 514; 591 NW2d 369, 374 (1998), quoting *Kratze v Indep Order of Oddfellows*, 442 Mich 136, 143 n 7; 500 NW2d 115 (1993). All four factors, especially when considered together, weigh heavily in favor of granting a preliminary injunction here. Granting a preliminary injunction is within the sound discretion of the Court. *City of Grand Rapids v Central Land Co*, 294 Mich 103, 112; 292 NW 579 (1940).

Because the Criminal Abortion Ban can be interpreted in a variety of ways—as written; as allowed under the specific holding of *Bricker*; or as enforceable as construed under the shifting federal abortion caselaw since *Roe*—there is grave uncertainty regarding what conduct is actually permitted and prohibited under the Criminal Abortion Ban. Further, the Michigan Supreme Court has never addressed whether the Criminal Abortion Ban as written violates the Michigan Constitution, which is critical to determining whether safe access to abortion can continue in this state. Since Plaintiffs and their patients do not know how the Ban will be interpreted, preserving the status quo during the pendency of this litigation is appropriate. See, e.g., *Slis v Michigan*, 332 Mich App 312, 359–360, 363–364; 956 NW2d 569 (2020).

This preliminary relief is both legally warranted and necessary today. The Criminal Abortion Ban's legality under the Michigan Constitution is entirely independent of its legality under the United States Constitution, see *People v Bullock*, 440 Mich 15, 27; 485 NW2d 866 (1992), so Plaintiffs' request for relief under Michigan law is not contingent on any specific ruling in *Dobbs*. Indeed, awaiting the date of the *Dobbs* decision before addressing Plaintiffs' Michigan constitutional claims will cause irreparable harm, as Plaintiffs face an increasingly chaotic period in which the prohibitions of the Criminal Abortion Ban are uncertain and open to multiple enforcers' varying interpretations.

I. PLAINTIFFS ARE LIKELY TO PREVAIL ON THEIR CLAIM THAT THE CRIMINAL ABORTION BAN IS UNCONSTITUTIONAL

A. The Criminal Abortion Ban Is Unconstitutionally Vague

Given the shifting federal doctrine arguably incorporated through *Bricker*, and the statute's own ambiguity, the Criminal Abortion Ban is unconstitutionally vague.

A statute is unlawfully vague if it "fails to provide fair notice of the proscribed conduct," or if it "is so indefinite that it confers unfettered discretion on the trier of fact to determine whether

the law has been violated." *People v Rogers*, 249 Mich App 77, 94–95; 641 NW2d 595 (2001), citing *Woll v Attorney General*, 409 Mich 500, 533; 297 NW2d 578 (1980); *Plymouth Charter Twp v Hancock*, 236 Mich App 197, 200–201; 600 NW2d 380 (1999). The Criminal Abortion Ban fails this standard for three reasons.

First, the Ban fails to provide fair notice of what conduct it proscribes because it is unclear whether *Bricker*'s construction of the statute froze in place the protections of *Roe* as the *Bricker* Court then understood them, or whether instead the statute's prohibitions are dynamic, shifting automatically as federal constitutional law shifts over time. If the latter, it is also unclear at any given time what the statute prohibits, as the contours of *Roe* and its progeny are continually being litigated and modified, and remain in flux. The right to abortion recognized in *Roe* has been undermined in nearly fifty years of subsequent litigation, and the United States Supreme Court itself has weakened the standard federal courts use to assess abortion restrictions and upheld a number of restrictions not contemplated in *Roe* itself.

The United States Supreme Court first recognized the federal constitutional right to abortion nearly half a century ago, holding that states could not ban abortion before viability, or after viability to save the pregnant person's life or health. *Roe*, 410 US at 163–164. The Court has repeatedly affirmed this central holding. See, e.g., *June Med Servs LLC v Russo*, ___ US ___; 140 S Ct 2103, 2120; 207 L Ed 2d 566 (2020) (plurality opinion); *id.* at 2135 (Roberts, C.J., concurring); *Whole Woman's Health v Hellerstedt*, 579 US 582, ___; 136 S Ct 2292, 2300; 195 L Ed 2d 665 (2016); *Gonzales v Carhart*, 550 US 124, 146; 127 S Ct 1610; 167 L Ed 2d 480 (2007); *Planned Parenthood of Southeastern Pa v Casey*, 505 US 833, 846; 112 S Ct 2791; 120 L Ed 2d 674 (1992). Still, the contours of federal abortion doctrine have shifted significantly. See *Casey*, 505 US at 874 (plurality opinion) (holding that states can regulate pre-viability abortions so long

as they do not impose an "undue burden" on the right to abortion); *Gonzales*, 550 US at 133 (upholding a ban on a particular abortion method); *Whole Woman's Health*, 136 S Ct at 2300; *June Med*, 140 S Ct at 2112 (plurality opinion). Applying these shifting standards, federal courts of appeals have upheld restrictions on abortion not contemplated in *Roe*. See, e.g., *Preterm-Cleveland v McCloud*, 994 F3d 512, 517 (CA 6, 2021) (upholding law that bans abortion based on the patient's reason for having the abortion); *Bristol Reg'l Women's Ctr, PC v Slatery*, 7 F4th 478, 481 (CA 6, 2021) (upholding mandatory 48-hour delay requirement).

Federal abortion doctrine is likely to change again any day now. Last May, the United States Supreme Court granted certiorari in *Dobbs* to examine the constitutionality of Mississippi's ban on abortions after 15 weeks LMP—undisputedly before viability, contrary to *Roe*. The question the Court accepted in *Dobbs* takes aim at the very core of *Roe*, asking "[w]hether all pre-viability prohibitions on elective abortions are unconstitutional." Brief for Petitioners at i, *Dobbs*, 2021 WL 3145936; see also *id.* at 14 ("This Court should overrule *Roe* and *Casey*."); *Dobbs*, 141 S Ct 2619 (granting certiorari).

In light of these changing constitutional standards, the Michigan Supreme Court's decision in 1973 to construe the Criminal Abortion Ban through the lens of a federal constitutional doctrine, rather than strike down the statute as unconstitutional or enjoin its enforcement, has left the statute unconstitutionally vague for current providers, patients, and state actors. Arguably, *Bricker* rendered the Criminal Abortion Ban permanently inapplicable to any conduct that *Roe* protected as of the *Bricker* decision in 1973. But some state actors may nonetheless read *Bricker* as incorporating *Roe and its progeny*, and may attempt to enforce the Criminal Abortion Ban against conduct arguably left unprotected by post-*Roe* developments in federal constitutional jurisprudence. And given the imminent decision in *Dobbs*, the Ban as read in the light of changing

federal law is ever less clear. The Ban therefore quintessentially fails to provide fair notice of what it proscribes.

Second, even absent *Bricker*'s federal overlay, the Criminal Abortion Ban's plain text fails to provide fair notice of what conduct is prohibited. For example, the word "abortion" is not mentioned in the statute. MCL 750.14. Instead, the statute criminalizes the acts of "[a]ny person" who administers "any medicine, drug, substance or thing whatever" by "any . . . means whatever" to "procure the miscarriage of any [pregnant] woman." *Id.* The terms "miscarriage" and "pregnant" may be construed contrary to their commonly understood medical meanings by prosecutors and law enforcement who are emboldened or even merely confused.[8] The statute's "any . . . means whatever" catchall clause could similarly be read broadly by prosecutors hoping to initiate investigations into conduct other than providing an abortion. In this way, the Criminal Abortion Ban's terms are so indefinite that prosecutors could have broad discretion to assert that a range of undetermined medical practices are a crime, putting Dr. Wallett and other PPMI staff in the precarious position of not knowing what acts could subject them to criminal investigation or prosecution.

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

---

[8] For example, people who lack a complete or accurate understanding of reproductive medicine may interpret the Criminal Abortion Ban to criminalize conduct that is not abortion at all, such as prescribing emergency contraception. Wallett Aff ¶ 74 & n 72; see also, e.g. Oosting, *supra* note 6.

Court's interpretation of *Roe*, would remain if the decision in *Dobbs* further modifies *Roe*'s protections. See MCL 750.14. Additionally, *Bricker*'s interpretation did not address whether a subjective or objective standard governed its imported health exception. Cf *Women's Med Prof Corp v Voinovich*, 130 F3d 187, 205 (CA 6, 1997) ("[T]he combination of the objective and subjective standards without a scienter requirement renders these exceptions unconstitutionally vague, because physicians cannot know the standard under which their conduct will ultimately be judged."); *Summit Medical Assoc, PC v James*, 984 F Supp 1404, 1446–1448 (MD Ala, 1998), aff'd in part, rev'd in part on other grounds 180 F3d 1326 (CA 11, 1999).

The Criminal Abortion Ban as written is thus unconstitutionally vague, and made worse by *Bricker*'s possible incorporation of *Roe*'s shifting—and soon potentially obsolete—federal protections. The statute therefore fails to provide guidance as to what conduct it proscribes and encourages pretextual or discriminatory application.

B. The Criminal Abortion Ban Violates Rights Protected by the Michigan Constitution

Plaintiffs are likely to prevail on the merits of their additional claims that the Criminal Abortion Ban violates their rights under the Michigan Constitution to bodily integrity, equal protection, and liberty and privacy, as well as ELCRA.

Whether the Ban violates the Michigan Constitution "is not dependent on any determination by" the United States Supreme Court. See *Citizens Protecting Michigan's Constitution v Secretary of State*, 280 Mich App 273, 283; 761 NW2d 210 (2008), aff'd in part, lv den in part 482 Mich 960 (2008). The Michigan Supreme Court "alone is the ultimate authority with regard to the meaning and application of Michigan law." *Bullock*, 440 Mich at 27. As such, Michigan courts can "interpret the Michigan Constitution more expansively than the United States Constitution . . . ." *Id.* at 28; see also *id*. at 29 n 9 (listing examples); *People v Vaughn*, 491 Mich

642, 650 n 25; 821 NW2d 288 (2012). In *Mahaffey v Attorney General*, the Court of Appeals observed that "the existence of a federal constitutional right to abortion is not necessarily relevant to [the] determination" whether a state constitutional right to abortion exists. 222 Mich App at 333–334 (citation omitted). Quoting *Sitz v Department of State Police*, 443 Mich 744, 761–762; 506 NW2d 209 (1993), the Court of Appeals explained: "[a]ppropriate analysis of our constitution does not begin from the conclusive premise of a federal floor. . . . As a matter of simple logic, because the texts were written at different times by different people, the protections afforded may be greater, lesser, or the same." *Mahaffey*, 222 Mich App at 334 (omission in original).

Since Michigan's constitution stands independent of the federal constitution, Michigan courts are not bound by the contours of federal constitutional doctrine in applying any given state constitutional guarantee. See *Glover v Mich Parole Bd*, 460 Mich 511, 522; 596 NW2d 598 (1999); *Bauserman v Unemployment Ins Agency*, 503 Mich 169, 185 n 12; 931 NW2d 539 (2019); *Gilmore v Parole Bd*, 247 Mich App 205, 222; 635 NW2d 345 (2001); *Sitz*, 443 Mich at 761–762. Michigan courts are "free to find that an individual has greater rights under a Michigan constitutional provision than under its federal counterpart when compelling reasons to do so exist," *Glover*, 460 Mich at 522, "even where the language is identical," *People v Goldston*, 470 Mich 523, 534; 682 NW2d 479 (2004). Further, "'compelling reason' should not be understood as establishing a conclusive presumption artificially linking state constitutional interpretation to federal law." *Sitz*, 443 Mich at 758. As the Court explained in *Sitz*:

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

Multiple provisions of the Michigan Constitution bar the State from banning abortion. The Due Process Clause, Const 1963, art 1, § 17, protects a right to liberty that includes the right to bodily integrity, which both prohibits the State from forcing a person to become or remain pregnant without their consent, and prevents the State from forcing a pregnant person to face increased medical risks and interventions without their consent. The Equal Protection Clause, Const 1963, art 1, § 2, separately and in conjunction with ELCRA, MCL 37.2101 *et seq*., prevents the State from violating pregnant people's right to equality in the exercise of their fundamental rights to liberty and bodily integrity, and women's[9] right to be free of the sex stereotype that the biological capacity for pregnancy should determine the course of their life—as the Criminal Abortion Ban does by preventing people in Michigan from ending their pregnancies. Finally, separately and together, the Due Process Clause, Const 1963, art 1, § 17, and the Retained Rights Clause, Const 1963, art 1, § 23, protect a right to liberty and privacy that includes the right to abortion.

For all of these reasons, the Criminal Abortion Ban is likely to be found to violate Michigan law and should be preliminarily enjoined.

1. The Criminal Abortion Ban Violates the State Right to Bodily Integrity

Article 1, Section 17 of the Michigan Constitution establishes the right to due process, providing that "[n]o person shall . . . be deprived of life, liberty or property, without due process of law." Const 1963, art 1, § 17. The 1850 Michigan Constitution added this language for the first time, see Const 1850, art 6, § 32, and it has appeared in each subsequent version of the state constitution since, see Const 1908, art 2, § 16; Const 1963, art 1, § 17.

[9] While "woman" and "women" are recognized terms in equal protection jurisprudence, and while abortion restrictions have the effect of subordinating women as a class, Plaintiffs recognize that people of all gender identities may become pregnant and seek abortions.

The Due Process Clause of Michigan's Constitution protects a right to bodily integrity.[10] *Mays v Snyder*, 323 Mich App 1, 58–60; 916 NW2d 227 (2018), aff'd 506 Mich 157; 954 NW2d 139 (2020). The state constitutional right to bodily integrity stands independent of the federal constitution's protections. See *Glover*, 460 Mich at 522; *Sitz*, 443 Mich at 763; *Mays v Governor of Mich*, 506 Mich 157, 217; 954 NW2d 139 (2020) (MCCORMACK, C.J., concurring) ("[W]e are separate sovereigns. We decide the meaning of the Michigan Constitution and do not take our cue from any other court, including the highest Court in the land."). The essence of this right is a protection against nonconsensual bodily intrusions. *Mays*, 506 Mich at 192–195. The Criminal Abortion Ban violates that right by forcing people to remain pregnant against their will without sufficient justification, and by forcing pregnant people to face increased medical risk and more invasive medical interventions without sufficient justification.

In *Mays*, a case arising from the Flint water crisis, the Court of Appeals held that the plaintiffs had adequately pled a violation of the right to bodily integrity where they alleged that the state defendants' decision to switch Flint's water source to the Flint River caused "an egregious, nonconsensual entry into the body . . . . " 323 Mich App at 60, quoting *Rogers v City of Little Rock, Ark*, 152 F3d 790, 797 (CA 8, 1998). The Supreme Court affirmed by equal division the Court of Appeals's decision recognizing the state due process right to bodily integrity. *Mays*, 506 Mich at 192–195.

Lack of consent converts an otherwise acceptable or desired intrusion on a person's body, such as voluntarily elected medical treatment, into a violation of bodily integrity. The right to

[10] While the Court of Appeals in *Mahaffey* stated that the Michigan Constitution right to *privacy* does not protect the right to abortion, 222 Mich App at 334, 345, it did not address whether the Michigan Constitution's right to *bodily integrity* separately prohibits the State from forcing a person to remain pregnant against their will, or to endure increased medical risk and more invasive medical interventions without their consent, as the Criminal Abortion Ban does.

bodily integrity underpins the common-law doctrine of informed consent in medical decision-making. As the Court of Appeals recognized in *In re Rosebush*, 195 Mich App 675, 680; 491 NW2d 633 (1992), “Michigan recognizes and adheres to the common-law right to be free from nonconsensual physical invasions and the corollary doctrine of informed consent.” See also *In re Martin*, 200 Mich App 703, 710–711; 504 NW2d 917 (1993); accord *In re AC*, 573 A2d 1235, 1243 (DC, 1990) (en banc). Informed by this common-law doctrine, Michigan’s constitutional right to bodily integrity guards against nonconsensual physical intrusions.

Here, the Criminal Abortion Ban infringes the Michigan right to bodily integrity in two ways: first, it prevents people from exercising autonomy over their bodies and in turn the course of their lives; and second, it forces pregnant people to face increased medical risk and to undergo more invasive medical interventions without their consent by requiring them to remain pregnant and endure labor and delivery.

Forcing someone to remain pregnant against their will is a fundamental violation of their right “to the possession and control of [one’s] own person.” See *Mays*, 506 Mich at 212 (BERNSTEIN, J., concurring), quoting *Union Pacific R Co v Botsford*, 141 US 250, 251; 11 S Ct 1000; 35 L Ed 734 (1891). For a host of reasons, the decision to become or remain pregnant is one of the most personal and consequential a person will make in their lifetime. See *supra* pp 8–9. By preventing pregnant people in Michigan from ending their pregnancies, the Criminal Abortion Ban forces them to submit to nearly ten months of dramatic physical transformation, implicating the most personal aspects of their lives and identities, without their consent. See *supra* pp 8–9. In *Moe v Secretary of Administration & Finance*, 382 Mass 629, 648–649; 417 NE2d 387 (1981), the Supreme Judicial Court of Massachusetts recognized that the state constitutional “right to make the abortion decision privately” was “but one aspect of a far broader constitutional guarantee”

related to, among other things, the "strong interest in being free from nonconsensual invasion of . . . bodily integrity . . . ." (Citation omitted.) Similarly, in *Women of Minnesota v Gomez*, 542 NW2d 17 (Minn, 1995), the Minnesota Supreme Court agreed that "the state constitution protects a woman's right to choose to have an abortion" based on a prior decision recognizing, in the context of involuntary medical treatment, that the "right [of privacy] begins with protecting the integrity of one's own body and includes the right not to have it altered or invaded without consent," such that "the right to be free from intrusive medical treatment is a fundamental right encompassed by the right of privacy under the Minnesota Constitution," *id.* at 27, citing and quoting *Jarvis v Levine*, 418 NW2d 139, 148–150 (Minn, 1988) (alteration in original). Pregnant people in Michigan, too, have a strong liberty interest in being free from the "nonconsensual invasion" of their bodily integrity, and the Criminal Abortion Ban intrudes on it.

The Criminal Abortion Ban also forces pregnant people to endure increased physical risk, including an increased risk of death, and more invasive medical interventions such as delivery by cesarean section. Wallett Aff ¶¶ 21–34, 42. In *Hodes & Nauser, MDs, PA v Schmidt*, 309 Kan 610; 440 P3d 461 (2019) (per curiam), the Supreme Court of Kansas held that a state law banning the most common method of second-trimester abortion was likely to violate the state constitutional right to bodily integrity because it required people seeking abortions at that stage of pregnancy to undergo riskier and more invasive procedures instead, *id.* at 616–618, 646–650, 678.

Because the Criminal Abortion Ban infringes on the right to bodily integrity, it can be justified only if it is narrowly tailored to promote a compelling government interest. *Doe v Dep't of Social Servs*, 439 Mich 650, 662; 487 NW2d 166 (1992); *cf Guertin v State*, 912 F3d 907, 919 (CA 6, 2019) ("[I]ndividuals possess a constitutional right to be free from forcible intrusions on their bodies against their will, absent a compelling state interest." (Citation omitted.)). The

Criminal Abortion Ban has already been found not to advance the state's interest in protecting the health and safety of pregnant people in Michigan. See *People v Nixon*, 42 Mich App 332, 337–339; 201 NW2d 635 (1972), remanded 389 Mich 809 (1973), on remand 50 Mich App 38; 212 NW2d 797 (1973). To the contrary, the Ban exposes pregnant people to an increased risk of illness, serious bodily injury, and death. See *supra* pp 8–11. Accordingly, regardless of whether this interest is deemed "compelling," "important," or "legitimate," it cannot categorically justify the profound physical intrusion of forced pregnancy and childbirth.

2. The Criminal Abortion Ban Violates State Equal Protection Guarantees

The Criminal Abortion Ban violates the Michigan Constitution's Equal Protection Clause, Const 1963, art 1, § 2, for two distinct reasons. First, the law prevents some pregnant people but not others from exercising their fundamental rights to liberty, privacy, and bodily integrity under the Michigan Constitution. Second, the Criminal Abortion Ban is a sex-based classification that enforces antiquated and overbroad generalizations about women and requires women to undertake greater risks than men to their health, financial stability, and ability to exercise personal autonomy over their futures.

"When reviewing the validity of state legislation or other official action that is challenged as denying equal protection, the threshold inquiry is whether [a] plaintiff was treated differently from a similarly situated entity." *Shepherd Montessori Ctr Milan v Ann Arbor Charter Twp*, 486 Mich 311, 318; 783 NW2d 695 (2010). Then, if the difference in treatment infringes on a fundamental right or is based on a suspect classification, it is subject to heightened scrutiny. *Id.* at 319. Although Michigan courts deciding equal protection cases have employed a mode of analysis "similar" to that of the United States Supreme Court, *Doe*, 439 Mich at 662, "a state court is

entirely free to read its own State's constitution more broadly than [the United States Supreme Court] reads the Federal Constitution, or to . . . favor . . . a different [mode of] analysis of its corresponding constitutional guarantee," *City of Mesquite v Aladdin's Castle, Inc*, 455 US 283, 293; 102 S Ct 1070; 71 L Ed 2d 152 (1982).

Here, the Criminal Abortion Ban both infringes on a fundamental right and is based on a suspect classification. First, the Ban infringes on the exercise of a pregnant person's fundamental rights to liberty, privacy, and bodily integrity, which encompass the right to decide whether to remain pregnant. The Ban treats differently two classes of similarly situated people exercising that fundamental right: pregnant people who seek to terminate their pregnancy, and those who seek to continue their pregnancy to childbirth. Under the Ban, pregnant people who choose childbirth can more fully and without comparable government restriction exercise their rights to liberty, privacy, and bodily integrity by making highly personal decisions about their bodies, while those who seek to terminate their pregnancies are in almost all instances unable to do so. The two groups are similarly situated but treated differently.

Where, as here, legislation that treats similarly situated people differently infringes on a fundamental right, the court must employ strict scrutiny. *Doe*, 439 Mich at 662. When strict scrutiny is the test, it is the state's burden to establish that "the classification drawn is narrowly tailored to serve a compelling governmental interest." *Shepherd Montessori Ctr*, 486 Mich at 319. Assuming that the Criminal Abortion Ban's purported purpose—to protect against unsafe abortions, *Nixon*, 42 Mich App at 337–339—is arguably a compelling one, it is far from narrowly tailored to advance that interest. Abortions provided by licensed clinicians are highly safe, and are in fact safer than giving birth. See *supra* pp 8–9. Not only does the Ban fail to advance an interest

in “the health and safety of the woman,” but “it has become counter-productive.” *Nixon*, 42 Mich App at 340. By forcing people who do not wish to be pregnant to remain so and endure labor and delivery, the Ban exposes them to more medical risk than abortion. See *supra* pp 8–9. In sum, justifications rooted in a need to protect women or ensure their health and safety fail to stand up to constitutional scrutiny given how safe and common abortion is. See *supra* p 9. Thus, the Criminal Abortion Ban fails strict scrutiny because it is not necessary to further a compelling state interest and is not “precisely tailored” to that end. *Doe*, 439 Mich at 662.

Second, the Criminal Abortion Ban relies on a suspect classification because it is sex-based. On its face it applies only to women, and in operation it enforces the archaic, sex-based stereotype that the biological capacity for pregnancy should determine the course of a person’s life.

The Criminal Abortion Ban creates gender-based classifications in its text by specifically and repeatedly singling out the “pregnant *woman*” and “such *woman*.” MCL 750.14 (emphases added). Pregnancy-based classifications are sex-based classifications because they are justified by reference to physical differences between men and women. Cf *Mich Dep’t of Civil Rights ex rel Jones v Mich Dep’t of Civil Serv*, 101 Mich App 295, 304; 301 NW2d 12 (1980). In relying on these physical differences to justify differential treatment, such classifications codify sex-based stereotypes “that reflect[] ‘old notions and archaic and overbroad’ generalizations about the roles and relative abilities of men and women.” *Heckler v Mathews*, 465 US 728, 745; 104 S Ct 1387; 79 L Ed 2d 646 (1984), quoting *Califano v Goldfarb*, 430 US 199, 211; 97 S Ct 1021; 51 L Ed 2d 270 (1977) (plurality opinion). Distinctions drawn on the basis of pregnancy discriminate on the basis of sex.

The Criminal Abortion Ban also evidences discriminatory intent by enforcing sex-based stereotypes that, even if commonplace decades ago, are now obsolete and recognized as harmful and degrading. Principal among these stereotypes was the idea that "the female [was] destined solely for the home and the rearing of the family, and only the male for the marketplace and the world of ideas." *Stanton v Stanton*, 421 US 7, 14–15; 95 S Ct 1373; 43 L Ed 2d 688 (1975); see also *City of Cleburne, Tex v Cleburne Living Ctr*, 473 US 432, 441; 105 S Ct 3249; 87 L Ed 2d 313 (1985). Such notions "may not be used, as they once were, to create or perpetuate the legal, social, and economic inferiority of women." *United States v Virginia,* 518 US 515, 533–534; 116 S Ct 2264; 135 L Ed 2d 735 (1996), citing with disapproval *Goesaert v Cleary*, 335 US 464, 467; 69 S Ct 198; 93 L Ed 163 (1948), in which a 1945 Michigan statute prohibiting most women from obtaining bartender licenses was upheld, *id.* at 465, 467. By forcing people to carry pregnancies to term, the Criminal Abortion Ban attempts to conscript them to "the home and the rearing of the family," *Stanton*, 421 US at 14, despite the greater risks to their physical and mental health, financial stability, and ability to seek out life opportunities that result, see *supra* pp 11–13, and which are more than what is expected of and endured by men. In this way, the Criminal Abortion Ban perpetuates the subordination of women.

Where legislation creates a classification based on sex or gender, it is reviewed under the "intermediate" or "heightened scrutiny" test and fails constitutional muster unless it is substantially related to an important government interest. *People v Idziak*, 484 Mich 549, 570–571; 773 NW2d 616 (2009); see also *City of Cleburne*, 473 US at 440. Heightened scrutiny requires an "exceedingly persuasive" justification, *Communities for Equity v Mich High Sch Athletic Ass'n*, 459 F3d 676, 692–693 (CA 6, 2006), quoting *Virginia,* 518 US at 531, and "must not rely on

overbroad generalizations about the different talents, capacities, or preferences of males and females," *Virginia*, 518 US at 533.

As discussed previously, the State cannot meet that bar. The State's proffered justification of protecting women from unsafe abortions, see *Nixon*, 42 Mich App at 337–339, not only lacks a basis in fact, see *supra* pp 8–10, but it is also paternalistic—it relies on "overbroad generalizations" about the capacity of women to make their own medical decisions in consultation with trusted health care providers. And because the Criminal Abortion Ban directly undermines the State's purported interest in protecting women's health, see *supra* pp 8–13, it cannot be substantially related to furthering that interest.

3. The Criminal Abortion Ban Violates ELCRA

Michigan's Criminal Abortion Ban violates ELCRA because it deprives women of "the full and equal enjoyment" of public services and accommodations, as well as their ability to exercise their constitutional rights. MCL 37.2302(a). The Supreme Court has recognized that ELCRA: (1) "enlarge[s] the scope of civil rights" to include protection from discrimination on the basis of sex in public accommodations, housing, education, and employment, *Dep't of Civil Rights ex rel Forton v Waterford Twp Dep't of Parks & Rec*, 425 Mich 173, 186, 188; 387 NW2d 821 (1986); and (2) protects against "state action violations that amount to constitutional deprivation" in public services, *id.* Both of these components are violated here.

First, the Criminal Abortion Ban, by forcing women to remain pregnant without their consent, will cause them to be deprived of their civil rights in public accommodations, housing, education, and employment because of their sex. The Criminal Abortion Ban enforces a sex stereotype that women are meant to produce and raise children rather than take full advantage of

opportunities in education and employment. Enforcing the statute as written would make abortion virtually unavailable and thereby reduce people's access to education.[11] Similarly, forcing women to carry pregnancies to term limits their access to equal employment opportunities because pregnancy and childrearing significantly impact a woman's wage potential and career trajectory.[12] These denials of equal access violate ELCRA. *Clarke v K Mart Corp,* 197 Mich App 541, 545; 495 NW2d 820 (1992).

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

---

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

[12] See *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 Am J Pub Health 407, 409 (2018) (finding unemployment rates significantly higher among group forced to carry a pregnancy to term at six months after abortion was sought); see also Wallett Aff ¶¶ 49, 80–81; Jones, *supra* note 11, at 16 ("[A]bortion access increases a woman's earnings later in life by $11,000 to $15,000/year as measured in 2018 USD, about a 37% increase, and increases family income by $6,000 to $10,000/year, a 10% increase."); Malik et al., *America's Childcare Deserts in 2018*, Ctr for Am Progress (December 6, 2018) <https://www.americanprogress.org/issues/early-childhood/reports/2018/12/06/461643/americas-child-care-deserts-2018/> (accessed April 4, 2022); Wallett Aff ¶¶ 40, 80–81.

against women by depriving women of the full and equal privileges of their constitutional rights under the Michigan Constitution. Accordingly, in addition to the Criminal Abortion Ban violating the Michigan Constitution directly, enforcing the Ban would violate ELCRA.

4. The Criminal Abortion Ban Violates the State Constitutional Right to Privacy and Liberty Under the Retained Rights Clause

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

This language was added during the 1961–62 Constitutional Convention. I Official Record, Constitutional Convention 1961–62, pp 466, 470. Its purpose was explicit: "The language recognizes that no bill of rights can ever enumerate or guarantee all the rights of the people and that *liberty under law is an ever growing and ever changing conception of a living society developing in a system of ordered liberty*." *Id.* at p 470 (emphasis added); see also II Official Record, Constitutional Convention 1961–62, p 3365 (stating that the section "recognizes that no Declaration of Rights can enumerate or guarantee all the rights of the people—*that it is presently difficult to specify all such rights which may encompass the future in a changing society*" (emphasis added)).

Thus, it is clear that the individual state constitutional rights expressly named in the Declaration of Rights are not exhaustive of the rights recognized in 1963. The Retained Rights Clause clearly anticipates and authorizes courts to recognize, infer, and enforce constitutional rights not textually recognized in 1963.

Similarly, the United States Supreme Court has recognized a right to privacy under the penumbra of rights including the substantive due process right of the Fourteenth Amendment and

the Ninth Amendment's unenumerated rights provision.[13] And the Supreme Court of Kansas recognized a privacy right to abortion based on an "inalienable natural rights" clause in its state constitution, concluding that the clause protects "a woman's right to make decisions about her body, including the decision whether to continue her pregnancy," even though that right was not listed expressly in the constitution's text. *Hodes & Nauser*, 309 Kan at 613.

The Michigan Constitution's Retained Rights Clause similarly protects a pregnant person's fundamental right to abortion. Society and medicine have changed dramatically since 1846 and 1931, when the Criminal Abortion Ban was originally enacted and most recently enacted, respectively. The Ban was enacted based on an antiquated belief that the State should control women's bodies for their own good, no matter how women's lives, autonomy, and roles would be circumscribed as a result. Pregnant people are autonomous individuals with a fundamental right to

[13] See, e.g., *Griswold v Connecticut*, 381 US 479, 484–486; 85 S Ct 1678; 14 L Ed 2d 510 (1965) (recognizing the right of marital privacy and finding the Ninth Amendment is part of the penumbra that creates privacy, along with Fourteenth and other amendments); *id.* at 486 (Goldberg, J., concurring) (emphasizing the importance of the Ninth Amendment in recognizing right to marital privacy); *Roe v Wade*, 410 US 113, 153; 93 S Ct 705; 35 L Ed 2d 147 (1973) (right to privacy "encompass[es] a woman's decision whether or not to terminate her pregnancy," citing the Ninth Amendment as part of the penumbra but basing its holding on the Fourteenth Amendment). See also *Lawrence v Texas*, 539 US 558, 564–566; 123 S Ct 2472; 156 L Ed 2d 508 (2003) (right of same-sex couples to private consensual sexual intimacy, citing, e.g., *Griswold*); *Obergefell v Hodges*, 576 US 644, 663; 135 S Ct 2584; 192 L Ed 2d 609 (2015) (right of same-sex couples to marry, citing, e. g., *Griswold*); *Loving v Virginia*, 388 US 1, 12; 87 S Ct 1817; 18 L Ed 2d 1010 (1967) (personal privacy includes right to marry); *Skinner v Oklahoma ex rel Williamson*, 316 US 535, 541; 62 S Ct 1110; 86 L Ed 1655 (1942) (procreation); *Eisenstadt v Baird*, 405 US 438, 453; 92 S Ct 1029; 31 L Ed 2d 349 (1972) (contraception); *Prince v Massachusetts*, 321 US 158, 166; 64 S Ct 438; 88 L Ed 645 (1944) (family relationships and child-rearing); *Advisory Opinion on Constitutionality of 1975 PA 227 (Questions 2–10)*, 396 Mich 465, 505–504; 242 NW2d 3 (1976) ("The United States Supreme Court has recognized the presence of constitutionally protected zones of privacy. . . . described as being within penumbras emanating from . . . . the 1st, 3rd, 4th, 5th, 9th and 14th Amendments to the United States Constitution." (Quotation marks omitted.)).

make decisions about their lives and bodies without government interference that puts their health and well-being at risk.

The common law further supports the fundamental right to abortion under the Retained Rights Clause of the Michigan Constitution. Although the common law did not formally recognize a right to reproductive liberty per se, "[i]t is undisputed that at common law, abortion performed before 'quickening'. . . was not an indictable offense." *Roe*, 410 US at 132. "[E]ven post-quickening abortion was never established as a common-law crime." *Id* at 135. So too in Michigan: at common law, abortion was not a crime prior to "quickening." *Nixon*, 42 Mich App at 335 & n 3. Not only was abortion *not* a crime at common law; women had a common law *right* to terminate a pregnancy. As one scholar describes it:

> English and American women enjoyed a *common-law liberty* to terminate at will an unwanted pregnancy, from the reign of Edward II to that of George III. The common-law liberty endured, in England, from 1327 to 1803; in America, from 1607 to 1830 [when states began to criminalize abortion].

Means, *The Phoenix of Abortional Freedom: Is a Penumbral or Ninth-Amendment Right About to Arise from the Nineteenth-Century Legislative Ashes of a Fourteenth-Century Common-Law Liberty?*, 17 NYLF 335, 336 (1971) (emphasis added). The Court in *Roe* characterized the common law as creating a *right* of a woman to terminate a pregnancy. 410 US at 140–141. Recent scholarship thoroughly analyzes the broad common law right to terminate a pregnancy, explaining that "[t]he entitlement to end one's pregnancy before the birth of a child existed in the law of crimes, torts, property, contracts, and equity, read separately and together, long before the United States Supreme Court found it in the Constitution." Bernstein, *Common Law Fundamentals of the Right to Abortion*, 63 Buffalo L Rev 1141, 1208 (2015); see also Bernstein, *The Common Law Inside the Female Body* (Cambridge University Press, 2018).

Thus Plaintiffs have shown they are likely to succeed in their claim of constitutional right to abortion under Michigan's Retained Rights Clause.

5. The State Due Process Right to Liberty and Privacy Protects the Right to Abortion

Finally, while lower courts may be bound by the Court of Appeals's holding in *Mahaffey* that the Michigan Constitution's right to privacy does not protect a right to abortion that is separate and distinct from the federal right, 456 Mich App at 334, 345, *Mahaffey* did not have before it the legality of the Criminal Abortion Ban. Moreover, *Mahaffey* insufficiently considered the Michigan Constitution's support for an independent state right to abortion grounded in the liberty and privacy interests protected by the Due Process Clause, Const 1963, art 1, § 17, as detailed below.

It is undisputed that the Michigan Constitution protects a right to privacy. The Michigan Supreme Court "has long recognized privacy to be a highly valued right," and it has stated that "[n]o one has seriously challenged the existence of a right to privacy in the Michigan Constitution." *Advisory Opinion on Constitutionality of 1975 PA 227 (Questions 2–10)*, 396 Mich 465, 504; 242 NW2d 3 (1976), citing *De May v Roberts*, 46 Mich 160; 9 NW 146 (1881). The Court has held that protected zones of privacy are found in Article 1 of the Michigan Constitution. *Id.* at 505. And finally, the Court has determined that "[t]he right to privacy includes certain activities which are fundamental to our concept of ordered liberty" and that "[r]ights of this magnitude can only be abridged by governmental action where there exists a 'compelling state interest.'" *Id.*, quoting *Roe*, 410 US at 155.

The Michigan Supreme Court has never explicitly addressed whether the state right to privacy includes the right to abortion. See *Doe*, 439 Mich at 669–670 (summarizing arguments on "both sides concerning the existence of a separate state right to an abortion" but finding it "unnecessary to decide [the] issue" given that the federal right to abortion resolved the case); see

also *Bricker*, 389 Mich at 527–528; *People v Nixon*, 389 Mich 809 (1973). However, the Court of Appeals has twice considered whether an independent right to abortion exists under the Michigan Constitution and has come out both ways.

In 1991, the Court of Appeals explicitly found that the Michigan Constitution protects the right to abortion. *Doe v Dir of Dep't of Social Servs*, 187 Mich App 493, 508; 468 NW2d 862 (1991), rev'd on other grounds 439 Mich 650; 487 NW2d 166 (1992). The plaintiff in *Doe* challenged the constitutionality, on due process and equal protection grounds, of a statute prohibiting the use of public funds to pay for an abortion unless necessary to save the pregnant person's life. Although deciding that there was no right to a *funded* abortion, *id.* at 499, 520, 529, the Court of Appeals explicitly concluded that the Michigan Constitution "affords a right to an abortion," *id.* at 508, based on the right to privacy that "[o]ur own Supreme Court acknowledged . . . under the United States Constitution and also found [] to be a right under the Michigan Constitution," *id*. (citing the right to privacy established in *De May*). The Court of Appeals then concluded that the statute violated the Equal Protection Clause of the Michigan Constitution and did not address whether it also violated the state due process right to abortion. *Id.* at 534–535. The Supreme Court reversed that decision but, as it only reviewed the equal protection claims, it did not reach the question whether the Due Process Clause of the Michigan Constitution protects the right to abortion. *Doe*, 439 Mich at 670.

By contrast, in *Mahaffey*, the Court of Appeals concluded that "the right of privacy under the Michigan Constitution does not include the right to abortion." 222 Mich App at 345. Following the Court of Appeals's decision in *Mahaffey*, the Supreme Court denied leave to appeal, 456 Mich 948 (1998), so again it did not address the constitutional question.

Other state courts have recognized a right to abortion stemming from their state constitutional rights to liberty and privacy. See, e.g., *Planned Parenthood of the Heartland ex rel State v Reynolds*, 915 NW2d 206, 237 (Iowa, 2018) (holding that "under the Iowa Constitution, . . . implicit in the concept of ordered liberty is the ability to decide whether to continue or terminate a pregnancy"); *Armstrong v State*, 296 Mont 361, 379; 989 P2d 364 (1999) ("Montana's constitutional right of individual privacy" guarantees "a woman's right to seek and obtain pre-viability abortion"); *Am Academy of Pediatrics v Lundgren*, 16 Cal 4th 307, 327; 940 P2d 797 (1997) (holding that "the right of a pregnant woman to choose whether to . . . have an abortion," is a "right of privacy" under the state constitution); *Hope v Perales*, 83 NY2d 563, 575; 634 NE2d 183 (1994) ("[T]he fundamental right of reproductive choice[] [is] inherent in the due process liberty right guaranteed by our State Constitution . . . ."); *Doe v Maher*, 40 Conn Supp 394, 426; 515 A2d 134 (1986) ("Surely, the state constitutional right to privacy includes a woman's guaranty of freedom of procreative choice.").[14]

This is an unsettled area of Michigan law. Despite the Supreme Court's silence, abortion falls squarely within the zone of privacy that is protected under Michigan's constitution, and the question of whether the right to abortion is part of the state due process right to liberty and privacy is ripe for Michigan Supreme Court review.

Assuming the Michigan Constitution protects a fundamental liberty and privacy right to abortion, the Criminal Abortion Ban's intrusion on that right is unconstitutional unless it is

[14] See also *Valley Hosp Ass'n v Mat-Su Coalition for Choice*, 948 P2d 963, 964, 968–969 (Alas, 1997) (striking down abortion restriction for violating Alaska's "fundamental right to [] abortion . . . encompassed within" the state's right-to-privacy constitutional protection); *In re TW*, 551 So 2d 1186, 1192–1193 (Fla, 1989) ("Florida's privacy provision is clearly implicated in a woman's decision of whether or not to continue her pregnancy."); *Right to Choose v Byrne*, 91 NJ 287, 303–304; 450 A2d 925 (1982) (acknowledging a state-law right to choose whether to carry a pregnancy to term or to have an abortion).

narrowly tailored to advance a compelling state interest. *Doe*, 439 Mich at 662; *Phillips v Mirac, Inc*, 470 Mich 415, 432–433; 685 NW2d 174 (2004). The Court of Appeals has already observed that the Criminal Abortion Ban's purpose—to protect pregnant people from unsafe abortions—is insufficient to justify the Criminal Abortion Ban given that abortion is safe as provided by licensed clinicians in Michigan. *Nixon*, 42 Mich App at 339; see also *supra* p 9. Accordingly, Plaintiffs are ultimately likely to prevail on their claim that the Ban does not survive strict scrutiny.

II. PLAINTIFFS WILL SUFFER IRREPARABLE HARM WITHOUT AN INJUNCTION

The prospective harm to a plaintiff is "evaluated in light of the totality of the circumstances affecting, and the alternatives available to," the party seeking injunctive relief. *State Employees Ass'n v Dep't of Mental Health*, 421 Mich 152, 166–167; 365 NW2d 93 (1984). Plaintiffs here seek relief to maintain the status quo while the courts decide the constitutional questions presented. Absent an injunction, Plaintiffs will face legal uncertainty without protection from investigations, prosecutions, and administrative penalties for providing constitutionally protected abortions, and Plaintiffs' patients will face a risk of irreparable injury from the violation of their constitutional rights. "[W]hen reviewing a motion for a preliminary injunction, if it is found that a constitutional right is being threatened or impaired, a finding of irreparable injury is mandated." *Am Civil Liberties Union of Ky v McCreary Co*, 354 F3d 438, 445 (CA 6, 2003), citing *Elrod v Burns*, 427 US 347, 373; 96 S Ct 2673; 49 L Ed 2d 547 (1976) (holding that in an area of fundamental constitutional rights, the loss of constitutional rights "for even minimal periods of time[] unquestionably constitutes irreparable injury"); see also *Roman Catholic Diocese of Brooklyn v Cuomo*, ___ US ___; 141 S Ct 63, 67; 208 L Ed 2d 206 (2020) (per curiam).

Without fair notice of what the Criminal Abortion Ban prohibits, and given the possibility that the Ban could be enforced any day now, Plaintiffs face irreparable harm including potential

arrest, prosecution, and more for violating the Criminal Abortion Ban. Unless this Court enters injunctive relief preserving the status quo, Plaintiffs may be forced to cease providing abortions altogether, thus depriving people of access to abortion and forcing many to carry their pregnancies to term against their will.

III. AN INJUNCTION WILL NOT INJURE DEFENDANT

Defendant, the Attorney General of the State of Michigan, is responsible for defending and enforcing the laws of the state, as well as supervising all Michigan county prosecutors. MCL 14.28–14.30; Const 1963, art 5, §§ 1, 3; see *Platinum Sports Ltd v Snyder*, 715 F3d 615, 619 (CA 6, 2013) (explaining that "local prosecutors . . . answer to the Attorney General").

In contrast to the harm that Plaintiffs and their patients will suffer absent an injunction, Defendant will incur no harm from an order maintaining the status quo while Michigan courts determine the scope of the Criminal Abortion Ban and its legality under the Michigan Constitution. *Gates v Detroit & M R Co*, 151 Mich 548, 551; 115 NW 420 (1908) ("The object of preliminary injunctions is to preserve the status quo, so that upon the final hearing the rights of the parties may be determined without injury to either."). An injunction would align with the expectations, reliance, and actions of people in Michigan for nearly fifty years.

Indeed, preserving the status quo benefits all parties. Leaving the Criminal Abortion Ban open to conflicting interpretations while this case is pending could require Defendant and state officials under her direction to expend public resources without the benefit of a ruling on the statute's constitutionality. All parties therefore have an interest in the clarification of their rights and obligations under the Criminal Abortion Ban. Cf *Duke Power Co v Carolina Environmental Study Group, Inc*, 438 US 59, 82; 98 S Ct 2620; 57 L Ed 2d 595 (1978).

IV. THE PUBLIC INTEREST IS SERVED AND NOT HARMED BY AN INJUNCTION

The public interest lies with protecting the rights of Michiganders and ensuring the

vindication of their civil rights. See *Barczak v Rockwell Int'l Corp*, 68 Mich App 759, 765; 244 NW2d 24 (1976) (finding that a "state . . . ha[s] strong public policies in favor of remedying any violation of an individual's civil rights"); *Liberty Coins, LLC v Goodman*, 748 F3d 682, 690 (CA 6, 2014) (recognizing that it is "always in the public interest to prevent the violation of a party's constitutional rights" (citation omitted)).

The public interest is not served by uncertainty regarding Plaintiffs' and their patients' fundamental constitutional rights. Nor would it be served by expending public resources to investigate and prosecute Plaintiffs for providing abortion—safe, common, and essential health care that people in Michigan have relied on for decades. And it is certainly not in the public interest to leave the Criminal Abortion Ban free to be enforced as written, devastating the health and futures of thousands of Michiganders.

CONCLUSION

For the reasons set forth above, the Court should enter a preliminary injunction, consistent with *Bricker*, restraining Defendant, her successors, agents, servants, employees, and attorneys, and all persons in active concert or participation with them, including all persons supervised by Defendant, from enforcing or giving effect to MCL 750.14 and any other Michigan statute or regulation to the extent that it prohibits abortions authorized by a licensed physician before viability, or after viability when necessary in the physician's judgment to preserve the life or health of the pregnant person.

Respectfully submitted,

/s/ *Deborah LaBelle*
DEBORAH LaBELLE (P31595)
221 N. Main St., Ste. 300
Ann Arbor, MI 48104
(734) 996-5620
deblabelle@aol.com

MARK BREWER (P35661)
17000 W. 10 Mile Rd.
Southfield, MI 48075
(248) 483-5000
mbrewer@goodmanacker.com

HANNAH SWANSON*
Planned Parenthood Federation of America
1110 Vermont Ave. NW, Ste. 300
Washington, DC 20005
(202) 803-4030
hannah.swanson@ppfa.org

SUSAN LAMBIASE*
Planned Parenthood Federation of America
123 William St., 9th Floor
New York, NY 10038
(212) 261-4405
susan.lambiase@ppfa.org

BONSITU KITABA-GAVIGLIO (P78822)
DANIEL S. KOROBKIN (P72842)
American Civil Liberties Union Fund of Michigan
2966 Woodward Ave.
Detroit, MI 48201
(313) 578-6800
bkitaba@aclumich.org
dkorobkin@aclumich.org

MICHAEL J. STEINBERG (P43085)
RUBY EMBERLING**
AUDREY HERTZBERG**
HANNAH SHILLING**
Civil Rights Litigation Initiative
University of Michigan Law School
701 S. State St., Ste. 2020
Ann Arbor, MI 48109
(734) 763-1983
mjsteinb@umich.edu

**Pro hac vice application forthcoming*
***Student attorney practicing pursuant to MCR 8.120*

ATTORNEYS FOR PLAINTIFFS

Dated: April 7, 2022

EXHIBIT 1

STATE OF MICHIGAN
IN THE COURT OF CLAIMS

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

Plaintiffs,

v

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

Defendant.
_________________________________/

Case No.

Hon.

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

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

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

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

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

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

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

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

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

My Education and Professional Background

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

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

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

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

Planned Parenthood of Michigan

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

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

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

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

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

[1] See MCL 333.17015(3).

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

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

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

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

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

---

[2] MCL 722.903–722.904.

[3] MCL 550.541–550.551.

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

Pregnancy Has Significant Medical, Financial, and Personal Consequences

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

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

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

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

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

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

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

---

[6] *Id.*

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

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

[9] *Id.* at 3–4.

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

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

[12] *Id.*

[13] *Id.* at 1676.

[14] *Id.*

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

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

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

---

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

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

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

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

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

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

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

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

---

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

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

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

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

---

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

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

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

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

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

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

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

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

---

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

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

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

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

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

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

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

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

---

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

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

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

[31] *Id.*

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

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

---

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

[33] *Id.*

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

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

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

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

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

[39] See *id.*

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

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

---

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

[41] *Id.*

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

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

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

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

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

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

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

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

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

Background on Abortion

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

---

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

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

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

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

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

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

---

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

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

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

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

[55] *Id.*

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

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

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

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

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

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

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

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

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

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

---

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

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

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

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

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

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

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

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

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

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

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

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

---

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

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

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

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

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

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

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

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

My Medical Practice as an Abortion Provider

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Consequences of Banning Abortion in Michigan

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

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

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

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

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

---

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

[69] *Id.*

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

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

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

---

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

[71] See generally *id.*

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

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

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

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

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

---

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

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

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

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

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

---

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

---

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

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

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

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

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

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

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

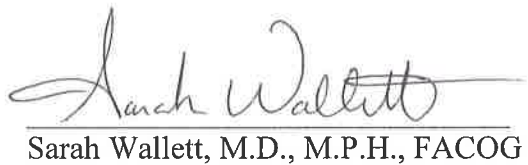
92. Not knowing when or how the law will change makes it hard for PPMI to plan even a month in advance. For example, while we try to see people for their abortion appointments as soon as the patient is firm in their decision and available, at some of our health centers we must

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

FURTHER AFFIANT SAYETH NAUGHT.

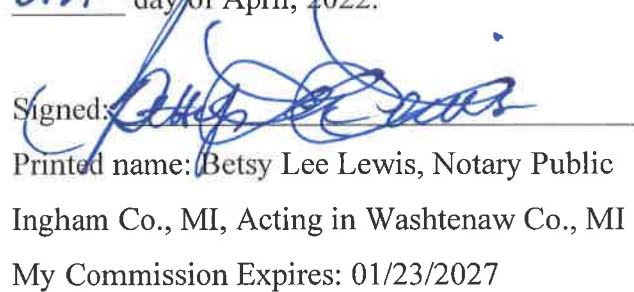
STATE OF MICHIGAN)
)ss
COUNTY OF WASHTENAW)

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



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

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



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