D-1-GN-23-000968

CAUSE NO. _____

AMANDA ZURAWSKI; LAUREN MILLER; LAUREN HALL; ANNA ZARGARIAN; ASHLEY BRANDT; DAMLA KARSAN, M.D. on behalf of herself and her patients; and JUDY LEVISON, M.D., M.P.H. on behalf of herself and her patients,

Plaintiffs,

v.

STATE OF TEXAS; ATTORNEY GENERAL OF TEXAS; KEN PAXTON, in his official capacity as Attorney General of Texas; TEXAS MEDICAL BOARD; and STEPHEN BRINT CARLTON, in his official capacity as Executive Director of the Texas Medical Board,

Defendants.

IN THE DISTRICT COURT OF

TRAVIS COUNTY, TEXAS

_____ JUDICIAL DISTRICT

353RD, DISTRICT COURT

PLAINTIFFS' ORIGINAL PETITION FOR DECLARATORY JUDGMENT AND APPLICATION FOR PERMANENT INJUNCTION

As a direct result of Texas's abortion bans, Texas is in the midst of a health care crisis. Amanda Zurawski, Lauren Miller, Lauren Hall, Anna Zargarian, Ashley Brandt, and countless other pregnant people have been denied necessary and potentially life-saving obstetrical care because medical professionals throughout the state fear liability under Texas's abortion bans. Amanda was forced to wait until she was septic to receive abortion care, causing one of her fallopian tubes to become permanently closed. When Lauren M. learned one of her twins was not viable, she was forced to travel out of state for the abortion she needed to save her and her other baby's life, who is due in several weeks. Lauren H. received a devastating fetal diagnosis two weeks after *Roe* was overturned, and in the chaos that followed, she was forced to travel to Seattle for an abortion. Pregnant again now, Lauren H. fears that Texas is not safe for her or her family. Anna was forced to fly across multiple states after her water broke, risking that she would go into

labor or septic shock on the journey. Ashley had to travel out of state to for an abortion to save the life of one of her twins, and afterwards, fearful of documenting Ashley's abortion, her Texas physician instead described her condition as "vanishing twin syndrome."

Yet with the threat of losing their medical licenses, fines of hundreds of thousands of dollars, and up to 99 years in prison lingering over their heads, it is no wonder that doctors and hospitals are turning patients away—even patients in medical emergencies like Amanda, Lauren M., Lauren H., Anna, and Ashley. Plaintiffs file this Original Petition for Declaratory Judgment and Application for a Permanent Injunction because uncertainty surrounding the meaning of the exception to Texas's abortion bans, codified at Tex. Health & Safety Code §§ 170A.001-002 (the exception to the Trigger Ban) and Tex. Health & Safety Code §§ 171.002(3), 171.203-205 (the "medical emergency" exception to Senate Bill 8 of 2021) (collectively, the "Emergent Medical Condition Exception"), has caused and threatens to cause irreparable injury to Plaintiffs and the Physician Plaintiffs' patients. In support of their petition, Plaintiffs respectfully show the following:

INTRODUCTION

1. Abortion bans harm the health of women and pregnant people. In September 2021, Senate Bill 8 ("S.B. 8") effectively imposed a statewide ban on abortion after approximately 6 weeks of pregnancy.[1] After the U.S. Supreme Court overturned *Roe v. Wade* in June 2022, Texas's near-total abortion ban took effect. Texans have suffered catastrophic harms because of those bans. Pregnant people in Texas and throughout the country have suffered unnecessary physical and emotional pain and harm, including loss of their fertility. These pregnant people are not

[1] Consistent with standard medical practice, gestational ages as used in this petition are dated from the first day of the patient's last menstrual period ("LMP"), which is typically approximately two weeks before the estimated date of fertilization of a pregnancy.

hypothetical. They are not unknown. They are real people with families, many with children already, and some of them are plaintiffs in this action.

2. Local newspapers and social media abound with stories of abortion bans harming pregnant people and their families, a large number of whom live in Texas. In every person's story, the same themes emerge: First, abortion is necessary health care that is being denied under Texas's civil and criminal abortion bans. Second, abortion bans are preventing pregnant people from receiving the standard of care from their medical professionals in times of crisis. And third, pervasive fear and uncertainty throughout the medical community regarding the scope of the life and health exceptions have put patients' lives and physicians' liberty at grave risk.

3. Abortion bans are hindering or delaying necessary obstetrical care. And, contrary to their stated purpose of furthering life, the bans are exposing pregnant people to risks of death, injury, and illness, including loss of fertility—making it *less* likely that every family who wants to bring children into the world will be able to do so and survive the experience. Medical professionals are now telling their patients that if they want to become pregnant, they should leave Texas.

4. Plaintiffs represent only the tip of the iceberg. Since September 2021, millions of people of reproductive capacity in Texas and beyond have been denied dignified treatment as equal human beings. This Court need not guess at the impact that abortion bans have. Each day, in states across the country, pregnant people like Amanda, Lauren M., Lauren H., Anna, and Ashley are being denied their ability to control their reproductive lives and to build their families according to their own values and beliefs. Medical professionals are being forced to forgo practicing their profession and fulfilling their ethical duties to patients in the face of catastrophic risks to their liberty and livelihood. Plaintiffs' experiences illustrate that while the stated purpose of Texas's

abortion bans may have been to promote healthy babies and families, the bans have done the opposite.

5. Plaintiffs respectfully ask this Court for a declaratory judgment clarifying the scope of Texas's Emergent Medical Condition Exception to its abortion bans, and any and all declaratory or injunctive relief necessary to protect the health and lives of pregnant Texans with emergent medical conditions.

DISCOVERY CONTROL PLAN

6. Plaintiffs request that this case be conducted as a Level 3 case for the purposes of discovery in accordance with Texas Rule of Civil Procedure 190.4. In addition, pursuant to Texas Rule of Civil Procedure 47(c)(5), Plaintiffs state that they seek non-monetary relief only.

PARTIES

I. PLAINTIFFS

A. Amanda Zurawski

7. Amanda Zurawski is 35 years old and lives in Austin, Texas.

8. Amanda and her husband have known each other since preschool and were married in 2019. They have long wanted to have children. When they started trying for a baby, however, Amanda learned she was not ovulating. After a year and a half of fertility treatments—which included exploratory procedures, use of multiple medications, one misdiagnosis, and treatment with intrauterine insemination or IUI—Amanda finally got pregnant for the first time.

9. Amanda's pregnancy proceeded without incident until, at 17 weeks, 6 days, she was diagnosed with an "incompetent cervix"—weakening of the cervical tissue that causes

premature dilation of the cervix. Because her pregnancy was still so many weeks before viability, she was told that her baby[2] would not survive.

10. Amanda and her husband were devastated and kept asking if there was something, anything, her doctors could do. Amanda specifically asked if she was a candidate for cerclage, a procedure where a patient's cervix is stitched closed to prevent preterm birth. Her doctors told her that unfortunately, her membranes were already prolapsing, meaning that a cerclage procedure would be too risky and, in any event, would not be successful.

11. Amanda was sent home, and that night, her water broke. It was Tuesday, August 23, 2022.

12. Amanda returned to the emergency room that night and was diagnosed with preterm prelabor rupture of membranes (also known as preterm premature rupture of membranes, or "PPROM"). Because all of Amanda's amniotic fluid drained when her water broke, the emergency room kept her overnight in hopes that she would go into labor on her own. In the morning, however, she had not gone into labor, her baby still had cardiac activity, and her vitals were still "stable," meaning she was not *yet* showing signs of acute infection.

13. Amanda was told that under Texas's abortion ban, there was no other medical care the hospital could provide. At this point, absent Texas's abortion bans, a patient in Amanda's situation would have been offered an abortion or transferred to a facility that could offer the procedure. But Amanda was offered neither because the hospital was concerned that providing an abortion without signs of acute infection may not fall within the Emergent Medical Condition Exception in Texas's abortion bans.

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

14. Amanda was told that delivery could take hours, days, or weeks. Once Amanda heard it could take hours, she decided there was no time to travel to another state for an abortion. She looked it up, and the drive to the closest abortion provider, in Albuquerque, New Mexico, would be 11 hours. The specialist at the hospital also urged Amanda to stay within a 15-minute drive of the hospital, in case her health deteriorated quickly.

15. On Wednesday morning, Amanda was sent home with instructions to monitor herself for signs of infection.

16. Amanda spent Wednesday and Thursday at home, grieving her inevitable loss and worrying about her own health.

17. On Thursday morning, Texas's Trigger Ban went into effect.

18. On Friday morning, Amanda went for a check-up at her obstetrician's office. At her appointment, her vitals were still "stable."

19. On the drive home from her obstetrician's office, however, Amanda developed chills and started shivering, and by the time she got home, she had a temperature of 101 degrees and was not responding to her husband's questions—all signs of sepsis.

20. Amanda's husband called their obstetrician's office and while he was waiting for a call-back, decided he could wait no longer and needed to take her to the emergency room immediately.

21. By the time Amanda was admitted to the labor and delivery unit, her temperature was 102 degrees and peaked at 103.2 degrees. Her medical team confirmed she was indeed septic and put her on antibiotics. The hospital finally agreed she was sick enough that inducing labor would clearly not violate Texas's abortion bans.

22. Amanda delivered, and her baby, Willow, passed away.

23. That night, Friday, Amanda's fever subsided but her blood pressure and platelet levels remained abnormally low. Amanda was told that while the first infection had cleared, she had developed a secondary infection, chorioamnionitis, and septic shock. The subsequent bout of sepsis landed her in the intensive care unit ("ICU").

24. Amanda spent three days in the ICU while her infection was treated. Amanda's family flew to Austin from across the country because they worried it would be the last time they would see her.

25. Amanda was eventually discharged and returned home, but her suffering was far from over. The infections had caused such severe scar tissue to develop in her uterus and on her fallopian tubes that it obscured x-ray imaging of her reproductive organs. She had a procedure to attempt to remove the scar tissue, and while her physicians were able to clear her uterus and one of her fallopian tubes, the other fallopian tube remains permanently closed.

26. Amanda has been advised by her reproductive specialist that to get pregnant again, she should start in vitro fertilization ("IVF"), which involves its own invasive procedures and uncertain success.

27. Amanda has already begun IVF treatments.

28. Once a pregnant person has been diagnosed with an incompetent cervix in one pregnancy, the risk is high that they will develop the same condition in future pregnancies.

29. Amanda and her husband have been trying to have children for years, and she not only lost her first pregnancy, but because of Texas's abortion bans, she nearly lost her own life and spent days in the ICU for septic infections whose lasting impacts threaten her fertility and, at a minimum, make it more difficult, if not impossible, to get pregnant again in the future.

30. Amanda's claims are capable of repetition but evading review. Amanda sues on her own behalf.

B. Lauren Miller

31. Lauren Miller is 35 years old and lives in Dallas, Texas.

32. Lauren M. first learned she was pregnant from a pharmacy urine test in July 2022, and quickly realized that the first day of her last menstrual period, the date from which her pregnancy would be dated, was June 24, 2022, the same day *Roe v. Wade* was overturned.

33. Lauren M. already has an 19-month-old son, and she and her husband were excited to have another child join their family. She started keeping a pregnancy journal to document the details of her pregnancy and her emotions about her pregnancy. Lauren M. scheduled her first prenatal visit for approximately 8 weeks.

34. Before her first prenatal visit, however, Lauren M.'s health took a turn for the worse. She experienced horrible nausea and vomiting and could not keep food or even water down. After 36 hours of continuous vomiting, Lauren M. went to the emergency room for treatment for dehydration. At the emergency room, Lauren M. had her first ultrasound and learned she was pregnant with twins. She and her husband were shocked but thrilled.

35. At the emergency room, Lauren M. was also diagnosed with hyperemesis gravidarum, a severe form of persistent nausea that can last throughout pregnancy and cause significant risks for pregnant people and their babies.

36. Lauren M. began treatment for hyperemesis gravidarum but did not respond to medications and continued to struggle with nausea and vomiting as her pregnancy progressed.

37. At Lauren M.'s 12-week ultrasound appointment, she learned that Baby B was not growing as fast as Baby A, and while that was a cause for potential concern, obtaining a diagnosis would require additional monitoring and testing. Lauren M. provided a blood sample for

noninvasive prenatal blood testing ("NIPT"), which can be done between 10 and 13 weeks to screen for some fetal conditions. While Lauren M. was still waiting for the NIPT results, she returned a week later for another ultrasound and learned that Baby B had developed two cystic hygromas, fluid filled sacs near the brain. While worrisome, Lauren M.'s physicians still could not yet diagnose Baby B's medical condition and recommended additional testing, specifically chorionic villus sampling ("CVS") or amniocentesis, which involves a needle procedure into the placenta or amniotic fluid.

38. Several days later, Lauren M. received the results from her NIPT test, which indicated that Baby B likely had trisomy 18, a condition with a very high likelihood of miscarriage or stillbirth and low survival rates beyond the first year of life.

39. Lauren M. met with a genetic counselor who struggled to give clear information regarding what this result meant for her pregnancy under Texas's new abortion bans. After receiving a referral to a maternal-fetal medicine ("MFM") specialist who could perform CVS testing, Lauren M. scheduled the first available appointment, which was for the following day.

40. The following day, Lauren M. visited an MFM specialist who performed a high-resolution ultrasound and attempted CVS testing. The MFM confirmed via ultrasound that Baby B had multiple fetal structural abnormalities—cystic hygromas where much of the brain should have been developing, a single artery umbilical cord, incomplete abdominal wall, abnormal heart, abnormal nuchal translucency—and told Lauren M. and her husband that Baby B would likely not survive to birth. Because the ultrasound alone was so conclusive, and because Lauren M.'s uterus was contracting and preventing the needle from reaching the placenta of Baby B, the MFM did not ultimately complete the CVS test.

41. The MFM told Lauren M. and her husband that before S.B. 8, they would have been able to offer Lauren M. a fetal reduction (an abortion of Baby B) to give Baby A and Lauren M. the best chance to avert a health crisis. Now, all they could do was suggest that she travel out of state.

42. In every interaction with their medical team in Texas, Lauren M. and her husband felt confused and frustrated and could not get direct answers. It was apparent that their doctors, nurses, and counselors were all fearful of speaking directly and openly about abortion for fear of liability under Texas's abortion bans.

43. A few days after Lauren M.'s visit with the MFM, she was hospitalized again with complications from hyperemesis gravidarum. Lauren M. was vomiting so violently that she was unable to drive herself to the emergency room and had debilitating chills and severe dehydration requiring hospitalization. If not for Texas's abortion bans, Lauren M. would have had the fetal reduction before her subsequent emergency room visit.

44. Lauren M. and her husband remained deeply concerned about her health as well as that of Baby A. They ultimately decided to travel out of state to receive a selective fetal reduction abortion procedure. They named Baby B Thomas, and started to say goodbye.

45. At 15 weeks at a clinic in Colorado, Lauren M. underwent the selective reduction abortion procedure, which was quick and uncomplicated. Yet the procedure, plus the associated travel, cost thousands of dollars and required Lauren M. and her husband to be away from their son for two days.

46. After the procedure, Lauren M.'s hyperemesis gravidarum symptoms immediately subsided, and her pregnancy with Baby A has since progressed without complications. Lauren M.

lost so much weight from hyperemesis gravidarum that she did not return to her pre-pregnancy weight until 29 weeks.

47. Lauren M. is thankful that she had the funds and support from family, friends, and employers to allow her and her husband to travel for the health care she needed. She has friends in the medical field who helped her connect with doctors out of state. She knows that many other pregnant people have not been so fortunate.

48. Lauren M. was overjoyed to discover she was pregnant with twins, but after suffering from extreme hyperemesis gravidarum and a devastating fetal diagnosis for Baby B, Texas's abortion laws made it *less* likely that both she and Baby A would survive her pregnancy.

49. Lauren M. is due to give birth to Baby A at the end of March 2023. Lauren M. fears for her safety as a pregnant woman in Texas.

50. Lauren M.'s claims relate both to her current pregnancy and any future pregnancies and are capable of repetition but evading review. Lauren M. sues on her own behalf.

C. Lauren Hall

51. Lauren Hall is 28 years old and lives outside of Dallas, Texas.

52. Lauren H. and her husband were thrilled when they found out she was pregnant. At her first ultrasound at around 8 weeks, everything looked great. Because her pregnancy was uncomplicated, Lauren H. would not have another ultrasound until her anatomy scan, which is usually scheduled later than 16 weeks. In the meantime, Lauren H. started planning, telling friends and family the news, buying baby clothes and furniture, and even selected a name—Amelia.

53. Lauren H. knew that her OB/GYN was opposed to abortion. But at the time, it did not seem like a big deal.

54. Two weeks after *Roe v. Wade* was overturned, however, Lauren H. went to an appointment with an MFM specialist for her 18-week anatomy scan. Lauren H. is a nurse, and as the ultrasound began, she knew immediately that something was wrong.

55. Lauren H. was told that her baby had anencephaly, a condition where the baby does not develop a skull and has a severely underdeveloped brain. Lauren H. knew that with such a diagnosis, the baby had no chance of survival. Her MFM specialist told her that anencephaly is incompatible with life.

56. Lauren H. was told that there were many physical and mental risks to her if she continued the pregnancy, including hemorrhage and preterm birth. Lauren H. remembers thinking that she did not want to end up bleeding to death on the bathroom floor. She was scared that when something inevitably went wrong, she would not get proper care for this pregnancy in Texas. She decided that she wanted an abortion.

57. Lauren H.'s MFM specialist said she couldn't help her and was even fearful to give her information about her options. *Roe* had just been overturned and everyone Lauren H. encountered was terrified. Her MFM urged her to go out of state and tell no one—not her family, not anyone at the airport—where she was going or what she was doing. Lauren H.'s MFM said she could not provide a referral or even transfer her medical records to an abortion provider. No one knew how far the politicians in Texas would go to prosecute people involved in abortion care.

58. Lauren H. and her husband were grieving, were desperate for help, and they were made to feel like everything they needed was illegal.

59. Lauren H. tried to get an appointment with her OB/GYN, but he was out of town, and no one from the office was responding. Lauren H. even drove to her OB/GYN's office to ask for help in person, but no one would see her. Eventually, someone from the office called back but

only offered her information about support groups for patients who give birth to babies with anencephaly. Lauren H. realized she was on her own to figure out what to do.

60. Lauren H. called clinics in Colorado and New Mexico. Because *Roe* had just been overturned and abortion bans were taking effect in states throughout the South, the Colorado and New Mexico clinics were inundated with patients. They didn't have appointments.

61. Lauren H. has struggled with depression, and the stress of searching for care took a huge toll. Her mental health spiraled to the point that she considered checking herself into the hospital. But she was afraid to tell anyone what was going on because she worried what would happen to her if people knew she wanted an abortion.

62. Because she was already 18 weeks pregnant, Lauren H. worried that she was too far along to be seen by most clinics. Eventually, Lauren H. got an appointment at a clinic in Seattle that specializes in cases like hers. Lauren H. and her husband's family sent them money to help pay for the extremely expensive last-minute trip. On her way into the clinic for her appointment, protesters shouted at her that she was a baby killer.

63. Lauren H. and her family grieved their loss but are still processing the trauma of what happened to her and needing to travel so far from home during such a time of chaos and confusion, just to receive necessary health care.

64. Lauren H. is now pregnant again and due in September. She is both excited and scared because she fears that it is not safe for her or for anyone to be pregnant in Texas.

65. Lauren H.'s claims relate both to her current pregnancy and any future pregnancies and are capable of repetition but evading review. Lauren H. sues on her own behalf.

D. Anna Zargarian

66. Anna Zargarian is 33 years old and lives in Austin, Texas.

67. In September 2021, just a few weeks after S.B. 8 took effect, Anna realized that her period was two weeks late.

68. Anna and her now-husband were surprised to learn she was pregnant, but they were excited about having a baby. Anna remembers thinking that it was a good thing she did not want an abortion, as she may have already been past the cutoff for abortion care under S.B. 8.

69. Anna's pregnancy proceeded without incident until, at 19 and a half weeks, she felt a sensation like something was starting to come out of her body. Anna had some cramping but tried to put it out of her mind. Hours later, Anna felt a gush of liquid leave her body, then a second gush left a puddle on the floor. Anna knew something was wrong.

70. Anna and her husband went to the emergency room that night and learned that her water had broken prematurely, and her cervix had started dilating. She was diagnosed with PPROM. Anna was told that because all of the amniotic fluid had drained when her water broke, her baby would not survive to birth.

71. Doctors in the emergency room told Anna that for patients in her situation, they would usually recommend termination of the pregnancy. If she continued the pregnancy, she was at high risk of developing a septic infection or hemorrhaging. Anna works in health care, and as soon as she heard that she was at risk of sepsis, she panicked.

72. The doctors told her that the safest treatment for her was a D&E. But because of S.B. 8, as long as her baby had detectible cardiac activity, Texas law barred them from performing an abortion, unless and until her life was in imminent danger.

73. Anna tried to reason with the doctors in the emergency room. She asked if, instead of a D&E, they could induce her. But the doctors explained that an induction at this stage was also an abortion prohibited by law. When Anna asked for guidance, the medical staff at the hospital

were scared to give Anna any information about where to seek abortion care. Instead, one of the doctors typed a generic abortion finder resource into her cell phone and showed the webpage to Anna.

74. Anna was told that she could be admitted to the hospital for "expectant management"—where she would wait either to go into labor naturally, or for her health to deteriorate sufficiently for the hospital to be able to intervene. She was also told that she could wait until the morning to speak to an MFM specialist, but that the MFM would not be able to offer any different treatment.

75. Anna and her husband decided to go home so they could begin researching abortion options on their own. They debated what seemed less risky—an 11 hour drive to New Mexico, or a 2 hour flight to Colorado? Anna wanted to make sure the state she chose did not have a mandatory waiting period that would delay her care further. That night, Anna continued to leak amniotic fluid and experience cramping.

76. The next morning, Anna spoke to her longtime OB/GYN. Anna was concerned that if she went into labor while driving through rural Texas, there would be no hospital where she could access care. While she might go into labor or septic shock on the plane as well, at least the trip would be shorter and she could get to a doctor more quickly. Anna and her OB/GYN agreed: the best option given the circumstances was for Anna was to leave Texas for an abortion, and that a short flight was less risky than a long drive.

77. Anna called clinics in Colorado, but they were still being inundated by the influx of patients from Texas. A clinic in Denver was able to squeeze her in once she explained why she would not be able to wait weeks for an appointment. Anna bought a plane ticket and paid extra for a seat at the front of the plane near the bathroom. Thankfully, Anna arrived safely.

78. The morning of her procedure, Anna had a fever of 101, but she received an abortion and recovered well.

79. Since this experience, Anna has suffered from stress and anxiety, specifically related to the fear for her life she felt during the trip to Denver. She grieves the loss of a wanted pregnancy and still relives the trauma of being forced to leave Texas in the middle of a medical emergency.

80. Anna still wants to have children, but she is afraid of being pregnant again in Texas. Her doctors have told her that she will be at high risk for developing conditions associated with PPROM in future pregnancies.

81. Anna's claims are capable of repetition but evading review. Anna sues on her own behalf.

E. Ashley Brandt

82. Ashley Brandt is 31 years old and recently moved from Houston to Dallas, Texas.

83. Ashley and her husband got married in 2018 and already have a 3-year-old child. Ashley always wanted to have three children, so when she learned in May of 2022 that she was pregnant with twins, Ashley and her husband were thrilled.

84. During early prenatal visits, Ashley was told she was having identical twin girls, and that each had their own placenta and amniotic sac. Ashley and her husband love being parents and were excited about having twins. They began to tell their friends and family.

85. At her 12-week ultrasound, however, Ashley was told that Twin A's skull was much smaller than Twin B's, and Twin A did not appear to be developing normally. Ashley's OB/GYN explained that Twin A likely had acrania, a condition where the fetus does not develop a skull, and referred her to an MFM specialist for further testing.

86. For over a week, Ashley waited for her insurance to approve a visit with the MFM. She spent much of that week crying in bed. Still reeling from the news, and without guidance from her Texas physicians, Ashley started researching her options online and calling doctors in other states. A doctor in Colorado explained selective fetal reduction, and Ashley realized that an abortion of Twin A could help her save Twin B and herself.

87. Finally at the appointment, Ashley's Texas MFM confirmed that Twin A's skull was not properly developing and that the acrania had progressed to exencephaly, a precursor to anencephaly. The MFM warned Ashley that as long as Twin A continued growing, her chances of miscarriage or premature labor were high. Twin A's amniotic fluid would continue to break down brain tissue until she went into labor, at which point, she could lose both babies. Twin B might survive if born prematurely, but would require intensive neonatal care for months or longer. Further, if Twin A continued growing, there was also a risk of polyhydramnios, or excessive accumulation of amniotic fluid, which put Twin B at risk for fetal growth restriction.

88. Ashley did not want one stillborn, but she definitely did not want two.

89. There were significant risks for Ashley as well, particularly because she had a cesarian delivery with her first pregnancy. Ashley learned that polyhydramnios can lead to PPROM and/or placental abruption, meaning that Ashley was at risk of infection, bleeding, and hemorrhage. These risks were especially high because Twin A was the twin closest to her cervix.

90. Ashley asked her MFM about selective fetal reduction. Her MFM said that in another world, it would be simple, but this was Texas. And in Texas, abortion is illegal even if it means saving the life of a healthy baby. If Ashley wanted to go out of state for an abortion, that was her right and her MFM would send her medical records. But in Texas, all her physicians could do was monitor her at weekly appointments. Ashley was on her own.

91. Ashley made an appointment with the doctor in Colorado.

92. Ashley and her husband arranged for childcare, took time off work, and made the journey to Colorado. Her abortion procedure went smoothly, and Ashley and her husband flew home.

93. The day she returned home, however, Twin A's amniotic sac ruptured in the middle of the night and the bleeding and leaking fluid sent her to the emergency room. She was terrified that she would lose both babies and that she would somehow be in trouble for going out of state for the fetal reduction procedure. Thankfully, Twin B had a separate amniotic sac which was still intact.

94. In the emergency room, Ashley felt a distinct uneasiness and confusion. It appeared that the medical staff thought they were not supposed to know about Ashley's abortion or discuss it with her. To Ashley, everything felt secretive and icky.

95. The remainder of Ashley's pregnancy was plagued by fear and stress. Ashley's physicians recommended pelvic rest until her third trimester, as well as weekly ultrasounds that she had to pay for out of pocket. Ashley and her husband kept extra money in savings in case they had to leave the state again for medical care.

96. When Ashley reviewed her medical records, she saw a noticeable absence of documentation of her abortion. Her MFM's records contained no reference to their conversations about fetal reduction and at her appointment after the abortion, stated simply "SAB of Twin A," meaning "spontaneous abortion." At every one of her regular appointments with her OB/GYN following the abortion, her OB/GYN's records listed her diagnosis as "vanishing twin syndrome."[3]

[3] "Vanishing twin syndrome" is a type of miscarriage where one fetus in a multi-fetal pregnancy stops growing spontaneously and is absorbed into either the body of the pregnant person or (one of) the other fetus(es). *See Vanishing Twin Syndrome*, Cleveland Clinic, https://my.clevelandclinic.org/health/diseases/23023-vanishing-twin-syndrome.

It was not until she was a few weeks from her due date that her OB/GYN added the following note to her chart: "one twin with acrania and was electively terminated."

97. At 38 weeks, Ashley gave birth to a healthy baby.

98. Ashley feels fortunate that she could leave Texas for an abortion and thankful for the support of family and friends. While she had always planned to have more children, Texas's abortion bans make it hard for her to imagine getting pregnant again.

99. Ashley's claims are capable of repetition but evading review. Ashley sues on her own behalf.

F. Dr. Damla Karsan

100. Plaintiff Damla Karsan, M.D, is a board-certified OB/GYN in private practice at Comprehensive Women's Healthcare in Houston, Texas who is licensed to practice medicine in the state of Texas.

101. Dr. Karsan has practiced obstetrics and gynecology in Houston since 2001. As part of her practice, Dr. Karsan provides gynecological care, prenatal care, and obstetric care to her patients and to her colleagues' patients when she is on-call at the hospital where she has admitting privileges.

102. She is also trained to provide abortion care, and before S.B. 8, she routinely provided abortions to her patients as part of their comprehensive reproductive health care needs.[4]

103. Over her career, Dr. Karsan has personally treated pregnant patients with a wide variety of obstetrical and other health complications that develop during pregnancy, including but not limited to: miscarriage; ectopic pregnancy; management of fetal demise; complications of

[4] Before S.B. 8, Texas law generally permitted physicians to provide a limited number of abortions per year up to 18 weeks LMP in their private practices, or up to 22 weeks LMP in a hospital or ambulatory surgical center. *See* Tex. Health & Safety Code §§ 171.004, 171.045, 245.004.

pregnancy, including cervical insufficiency, PPROM, bleeding, preeclampsia, hyperemesis gravidarum; maternal comorbidities such as hypertension, diabetes, heart disease, kidney disease, cancer, rheumatologic disorders, psychiatric conditions, including those that may lead to suicide; complicated twin pregnancies; lethal fetal anomalies; various genetic diagnoses, including trisomy 13, 18, and 21; structural fetal abnormalities; and molar pregnancy. Dr. Karsan consults with specialists in the care of such patients—including but not limited to emergency medicine hospitalists, cardiologists, oncologists, anesthesiologists, and maternal fetal medicine doctors—and actively participates in the care of her patients who are treated for emergent health conditions during their pregnancies. Dr. Karsan intends to continue providing the full scope of care to her pregnant patients in the future.

104. Since S.B. 8 took effect, Dr. Karsan has seen the devastating impact of Texas's abortion bans on her practice and on that of her colleagues. In Dr. Karsan's experience, widespread fear and confusion regarding the scope of Texas's abortion bans has chilled the provision of necessary obstetric care, including abortion care. Dr. Karsan and her colleagues fear that prosecutors and politicians will target them personally and threaten the state funding of the hospitals where they work if they provide abortion care to pregnant people with emergent medical conditions.

105. Dr. Karsan has seen that physicians in Texas are even afraid to speak out publicly about this issue for fear of retaliation. Dr. Karsan feels she is only able to speak out publicly because she is in private practice and not directly employed by a state-funded hospital.

106. Dr. Karsan has also personally treated pregnant patients with emergent medical conditions since S.B. 8 took effect and consulted with colleagues about the care of such patients.

In Dr. Karsan's experience, an emergent condition or emergency situation cannot be formulaically defined and will always depend on the patient's unique situation.

107. Since *Roe v. Wade* was overturned, Dr. Karsan has treated patients with emergent medical conditions, including patients carrying pregnancies with lethal fetal conditions who needed treatment for complications like kidney stones, bipolar disorder, and hemorrhage. Before S.B. 8, Dr. Karsan would have offered abortion care to these patients. Now, Dr. Karsan instead has had to give them information about where to seek abortion care out of state.

108. Dr Karsan sues on her own behalf and on behalf of her patients.

G. Dr. Judy Levison

109. Plaintiff Judy Levison, M.D., M.P.H., is a board-certified OB/GYN licensed to practice medicine in the state of Texas. Dr. Levison is also a professor in the Department of Obstetrics and Gynecology at Baylor College of Medicine in Houston, Texas.

110. During her career, Dr. Levison has worked in private practice and in educational settings in Washington, California, and Texas providing obstetrical and gynecological care, including abortion, as well as teaching medical students, residents, and fellows. For the last 23 years, Dr. Levison has practiced obstetrics and gynecology in Houston and taught at Baylor College of Medicine, developing internationally recognized expertise in the treatment of pregnant people with HIV. Over her career, Dr. Levison has personally treated pregnant patients and consulted with relevant specialists regarding many different emergent conditions that arise during pregnancy, including, but not limited to: miscarriage; management of fetal demise; ectopic pregnancy; infections during pregnancy, including as a result of PPROM; bleeding and hemorrhage; comorbidities such as hypertension and diabetes; preeclampsia; hyperemesis gravidarum; heart conditions, including pulmonary hypertension and valve replacement; kidney disease; cancer, including cervical and breast cancer; rheumatological problems like lupus or

Sjogren's Syndrome; psychological conditions, including those that may lead to suicide; and various fetal diagnoses including trisomy 13, 18, and 21, neural tube defects like anencephaly, gastric and cardiac defects, Potter Syndrome (where the baby does not properly develop kidneys), and molar pregnancy.

111. Since S.B. 8 took effect, Dr. Levison has seen the devastating impact of Texas's abortion bans on her practice and on that of her colleagues. In Dr. Levison's experience, widespread fear and confusion regarding the scope of Texas's abortion bans has chilled the provision of the standard of practice of obstetric care, including counseling patients about the options for genetic screening for chromosomal diagnoses or neural tube defects and the options for abortion if a lethal fetal diagnosis was found. Dr. Levison and her colleagues fear that prosecutors and politicians will target them personally and threaten the state funding of their hospitals if they provide abortion care to pregnant people with emergent medical conditions.

112. Dr. Levison partially retired from the practice of medicine in July 2022 in part because, after the Supreme Court overturned *Roe v. Wade* and abortion became nearly completely banned in Texas, she felt she could no longer practice medicine the way she was trained and consistent with her ethical obligations as a physician. Texas's abortion bans have made it impossible for her to provide comprehensive, high quality reproductive care to her patients.

113. While she is partially retired, Dr. Levison can still see patients and regularly consults with colleagues regarding a wide array of pregnancy complications necessitating abortion care, including various specialists. She regularly consults with OB/GYN and MFM colleagues regarding the care of pregnant patients under Texas's abortion bans. Specifically, since S.B. 8 went into effect, Dr. Levison has consulted with and assisted colleagues regarding patient cases that arguably fall under the Emergent Medical Condition Exception, including patients with PPROM,

cancer, diabetes, hypertension, suicidal ideation, and who need fetal reduction procedures. Dr. Levison plans to continue to consult with her colleagues on these cases in the future.

114. Dr. Levison has seen that physicians in Texas are afraid to speak out publicly about Texas's abortion bans for fear of retaliation. Dr. Levison feels she is only able to speak out publicly because she is in the process of retiring.

115. Dr. Levison sues on her own behalf and on behalf of her patients.

116. Plaintiffs Dr. Karsan and Dr. Levison are collectively referred to throughout this Complaint as the "Physician Plaintiffs."

II. DEFENDANTS

117. Defendant State of Texas is responsible for the enforcement of Texas laws, including its abortion bans and the Emergent Medical Condition Exception. The State of Texas includes private citizens that could potentially enforce S.B. 8.

118. Defendant Ken Paxton is the Attorney General of Texas. As Attorney General, he is empowered to institute an action for a civil penalty against physicians licensed in Texas who violate or threaten to violate any provision of the Texas Medical Practice Act, including provisions triggered by a violation of the Trigger Ban. Tex. Occ. Code § 165.101; *id.* § 164.053. The Attorney General is additionally empowered to file a civil action against any person who violates the Trigger Ban, seeking a civil penalty of at least $100,000, plus attorney's fees and costs. Tex. Health & Safety Code § 170A.005. Defendant Paxton has threatened that he will "strictly enforce" the Trigger Ban.[5] Defendant Paxton is sued in his official capacity and may be served with process at 300 West 15th Street, Austin, Texas 78701.

[5] Ken Paxton, Tex. Att'y Gen., *Advisory on Texas Law Upon Reversal of* Roe v. Wade (June 24, 2022), https://www.texasattorneygeneral.gov/sites/default/files/images/executive-management/Post-Roe%20Advisory.pdf.

119. Defendant Texas Medical Board ("TMB") is the state agency mandated to regulate the practice of medicine by licensed doctors in Texas. TMB must initiate disciplinary action against licensees who violate any provision of the Texas Medical Practice Act or Chapter 171 of the Texas Health and Safety Code. Tex. Occ. Code § 165.001; *id.* § 164.055. TMB may impose discipline on a doctor who violates any state law "connected with the physician's practice of medicine" because such violation constitutes per se "unprofessional or dishonorable conduct." Tex. Occ. Code § 164.053(a)(1); *id*. § 164.052(a)(5); *see also id.* § 164.053(b) (making clear that "[p]roof of the commission of the act while in the practice of medicine . . . is sufficient" for discipline). TMB "shall" also "revoke the license, permit, registration, certificate, or other authority" of a physician who violates the Trigger Ban. Tex. Health & Safety Code § 170A.007. TMB may be served with process at 1801 Congress Avenue, Suite 9.200, Austin, Texas 78701.

120. Defendant Stephen Brint Carlton is the Executive Director of the TMB and in that capacity serves as the chief executive and administrative officer of TMB. Tex. Occ. Code § 152.051. Mr. Carlton is sued in his official capacity and may be served with process at 1801 Congress Avenue, Suite 9.200, Austin, Texas 78701.

JURISDICTION AND VENUE

121. This action is brought pursuant to Texas Rules of Civil Procedure 680 to 693, Texas Civil Practice and Remedies Code Chapter 65, and the common law of Texas to obtain declaratory and injunctive relief against Defendants.

122. This Court has jurisdiction over this matter, pursuant to the Texas Uniform Declaratory Judgments Act, Texas Civil Practice and Remedies Code § 37.001, *et seq.* ("UDJA"), Sections 24.007 and 24.008 of the Texas Government Code, and Texas Constitution, Article V, § 8.

123. Further, this Court has jurisdiction over Plaintiffs' request for declaratory and injunctive relief against Defendants because the UDJA waives sovereign and governmental immunity for challenges to the validity of statutes.

124. The Court also has jurisdiction over the Defendants sued in their official capacity because the *Ultra Vires* Doctrine permits claims brought against state officials for nondiscretionary acts unauthorized by law. *See* Tex. Civ. Prac. & Rem. Code §§ 37.003, 37.004, 37.006; *Tex. Lottery Comm'n v. First State Bank of DeQueen*, 325 S.W.3d 628, 634-635 (Tex. 2010); *Tex. Dep't of Transp. v. Sefzik*, 355 S.W.3d 618, 621-22 (Tex. 2011).

125. Finally, Texas's abortion bans are enforced through civil means, including steep civil penalties and disciplinary sanctions. *See, e.g.*, Tex. Occ. Code §§ 165.001, 164.052(a)(5), 164.053(a), 164.055; Tex. Health & Safety Code §§ 170A.005, 170A.007. This Court has jurisdiction to render a declaratory judgment regarding a civil enforcement scheme.

126. Although there are also potential criminal penalties for providing a prohibited abortion in Texas, this Court has jurisdiction to enter declaratory and injunctive relief because of the bans' civil penalties. Additionally, the Court has jurisdiction to enter declaratory and injunctive relief because criminal enforcement threatens irreparable injury to physicians' vested property interests in their medical licenses and liberty interests in pursuit of their chosen profession. *See Tex. Propane Gas Ass'n v. City of Houston*, 622 S.W.3d 791, 798–99 (Tex. 2021) (holding that district court had jurisdiction to render declaratory judgment regarding municipal criminal ordinances because the ordinances threatened irreparable injury to the plaintiff's property rights); *TitleMax of Tex., Inc. v. City of Austin*, 639 S.W.3d 240, 248 (Tex. Ct. App. 2021) (same). This Court also has jurisdiction because application of the abortion bans is causing pregnant people to face death, sustain physical injury, and endure extreme mental anguish, which is unconstitutional

and threatens irreparable injury to Physician Plaintiffs' and their patients' rights. *State v. Morales*, 869 S.W.2d 941, 942 (Tex. 1994).

127. Venue is proper in Travis County because Defendants State of Texas, Paxton, TMB, and Carlton reside or have their principal office in Travis County. Tex. Civ. Prac. & Rem. Code § 15.002(a).

128. Plaintiffs' request for prospective relief is specifically authorized as a request for a declaratory judgment under the UDJA. An action for a declaratory judgment is neither legal nor equitable but is sui generis—that is, of its own kind. *Tex. Liquor Control Bd. v. Canyon Creek Land Corp.*, 456 S.W.2d 891, 895 (Tex. 1970). Without such declaratory judgment, Plaintiffs have no meaningful remedy for their state law claims in accordance with Texas Constitution Article I, § 13.

FACTUAL ALLEGATIONS

I. BACKGROUND

A. Abortion is Health Care

129. Every major mainstream medical organization, including the American Medical Association ("AMA"), the American College of Obstetricians and Gynecologists ("ACOG"), the American College of Emergency Physicians ("ACEP"), and the Society for Maternal-Fetal Medicine ("SMFM"), recognize that abortion is necessary health care. These organizations are all opposed to governmental interference into patient-physician relationships. Such interference is contrary to the appropriate exercise of professional judgment that medical professionals need to exercise to protect patients' well-being. As the experiences of Amanda, Lauren M., Lauren H., Anna, and Ashley demonstrate, abortion bans are a paradigmatic example of such governmental interference.

130. The AMA recently updated its Principles of Medical Ethics to clarify that in the context of abortion, "physicians must have latitude to act in accord with their best professional judgment" and be "expressly permitt[ed] . . . to perform abortions in keeping with good medical practice."[6] The AMA also states that "Like all health care decisions, a decision to terminate a pregnancy should be made privately within the relationship of trust between patient and physician in keeping with the patient's unique values and needs and the physician's best professional judgment."[7]

131. ACOG, the nation's leading organization of physicians who provide health services unique to people seeking obstetric or gynecologic care, has long maintained the following policy on abortion: "All people should have access to the full spectrum of comprehensive, evidence-based health care. Abortion is an essential component of comprehensive, evidence-based health care."[8]

132. While state laws each adopt slightly different legal definitions for abortion, the medical definition of abortion is well understood: An abortion is the expulsion from the uterus of an embryo or fetus, as well as the products of conception, before viability.[9] In other words, an abortion is the termination and removal from the body of a pregnancy such that the pregnancy will not result in the birth of a living baby.

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[6] *AMA Announces New Adopted Policies Related to Reproductive Health Care*, Am. Med. Ass'n (Nov. 16, 2022), https://www.ama-assn.org/press-center/press-releases/ama-announces-new-adopted-policies-related-reproductive-health-care.

[7] *Amendment to Opinion 4.2.7, Abortion H-140.823*, Am. Med. Ass'n (2022) https://policysearch.ama-assn.org/policyfinder/detail/%224.2.7%20Abortion%22?uri=%2FAMADoc%2FHOD.xml-H-140.823.xml.

[8] *Abortion Policy*, ACOG (May 2022) https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/abortion-policy.

[9] *See, e.g.*, *Abortion*, Taber's Med. Dictionary, https://www.tabers.com/tabersonline/view/Tabers-Dictionary/766365/all/abortion#:~:text=abortion%20is%20a%20topic%20covered,fetus%20reaches%20a%20viable%20age.

133. While the medical treatment is generally the same, medical professionals may draw a distinction from the patient's perspective between a "spontaneous abortion" or "miscarriage"—where the embryo or fetus has no discernable cardiac activity—and an "induced abortion"— where the embryo or fetus has cardiac activity. The pregnant person's desire to have a baby or not, however, has no bearing on whether or not an abortion is considered spontaneous or induced.[10]

134. The majority of abortions in the United States are accomplished either through use of medications (medication abortion) or via an outpatient procedure (procedural abortion). Medication abortions are typically indicated up to 10.0 weeks and involve the ingestion of two medications to terminate the pregnancy, expelling the pregnancy via vaginal bleeding, akin to a heavy period or spontaneous miscarriage. Procedural abortions are possible throughout pregnancy and involve a two-step process where the medical provider first partially dilates the patient's cervix (using medications and/or mechanical or osmotic dilators), then evacuates the uterus using suction aspiration, instruments, or some combination. Dilation is done either the same day or the day before, and the evacuation phase of a procedural abortion typically takes around 5 minutes in the first trimester of pregnancy and 10-20 minutes in the second trimester, depending on the patient's response to the procedure and the complexity of the case.[11]

135. The only other medically proven abortion method is induction abortion, where a physician uses medication to induce labor and delivery of a non-viable fetus. Induction of labor accounts for only about 2% of second-trimester abortions nationally. Induction abortions must be performed in a hospital or similar facility that has the capacity to monitor a patient overnight and

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[10] *See Practice Bulletin 200: Early Pregnancy Loss*, ACOG (Nov. 2018) https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss; Andrew Moscrop, *Miscarriage or Abortion? Understanding the Medical Language of Pregnancy Loss in Britain; A Historical Perspective*, 39 Med. Humanities 98 (2013), https://mh.bmj.com/content/39/2/98.

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

provide pain management (e.g., epidural). Induction abortions can last anywhere from five hours to three days; are extremely expensive; entail more pain, discomfort, and recovery time for the patient—similar to giving birth—than procedural abortion; and are medically contraindicated for some patients.[12]

136. While some people attempt to stigmatize abortion care by misusing or conflating pregnancy terminology—e.g. villainizing particular methods of abortion or attempting to distinguish "elective abortion" from "miscarriage"—mainstream medical professionals understand that patients in any number of circumstances need abortions and that pregnant people, in consultation with their medical providers, should be able to choose the method of abortion appropriate for their circumstances.

B. Some Pregnancies Pose Emergent Medical Risks to Pregnant People's Lives and Health

137. All pregnancy care, including abortion, is time sensitive. Medically unnecessary delays in access to abortion care always harm pregnant people. Yet pregnancy can lead to any number of urgent or emergent conditions, if not outright medical emergencies, where especially prompt termination of pregnancy is necessary to preserve the life, health, and/or future fertility of the pregnant person. The American Board of Emergency Medicine ("ABEM") defines "emergent" conditions as cases where the "Patient presents with symptoms of an illness or injury that may progress in severity or result in complications with a high probability for morbidity if treatment is not begun quickly."[13]

[12] *See id.* at 5-8, 66-68.

[13] Michael S. Beeson et al., *The 2019 Model of the Clinical Practice of Emergency Medicine*, 59 J. of Emergency Med. 96 (2020), https://www.jem-journal.com/article/S0736-4679(20)30154-2/fulltext.

138. ACOG has emphasized that "it is impossible to create an inclusive list of conditions that qualify" as emergent or emergencies and thus fall under an exception to a state's abortion ban. Moreover, "it is dangerous to attempt to create a finite list of conditions to guide the practice of clinicians attempting to navigate their state's abortion restrictions." This is true for many reasons, including: "The practice of medicine is complex and requires individualization—it cannot be distilled down to a one-page document or list that is generalizable for every situation; No single patient's condition progresses at the same pace; A patient may experience a combination of medical conditions or symptoms that, together, become life-threatening; Pregnancy often exacerbates conditions or symptoms that are stable in nonpregnant individuals; There is no uniform set of signs or symptoms that constitute an 'emergency'; Patients may be lucid and appear to be in stable condition but demonstrate deteriorating health."[14] Nonetheless, medical organizations have described broad categories of types of conditions in pregnancy that are emergent.

139. ABEM's Model of Clinical Practice of Emergency Medicine, the definitive source and guide to the core content found on emergency physicians' board examinations, contains sections on "Complications of Pregnancy," "Complications of Labor," and "Complications of Delivery." The conditions include: (1) ectopic pregnancy; (2) conditions that can lead to dangerous bleeding or hemorrhage, including placental issues; (3) severe forms of hypertension; (4) conditions that can lead to dangerous infection, including premature rupture of membranes; and (5) extreme hyperemesis gravidarum (dangerous nausea and vomiting leading to hospitalization).[15]

[14] *Understanding and Navigating Medical Emergency Exceptions in Abortion Bans and Restrictions*, ACOG (Aug. 15, 2022), https://www.acog.org/news/news-articles/2022/08/understanding-medical-emergency-exceptions-in-abortion-bans-restrictions.

[15] *See* Beeson et al., *supra* note 13.

140. An ectopic pregnancy is a pregnancy where a fertilized egg implants and grows outside the uterine cavity, usually in the fallopian tube. Ectopic pregnancies cannot result in live births and are life threatening to the pregnant person because the pregnancy can rupture and cause massive internal bleeding. Ectopic pregnancies must be terminated with medication or surgery as soon as possible after diagnosis.[16]

141. Cesarian-scar ectopic pregnancy, where a pregnancy implants in the scar from a previous cesarean delivery, is considered an emergent condition where, like any other ectopic pregnancy, the recommended treatment is termination of pregnancy.[17]

142. Hemorrhaging during pregnancy is particularly dangerous for patients, as it can lead to organ damage, organ failure, or even death. A variety of pre-existing chronic health conditions and health conditions that develop during pregnancy can become emergent due to the risk of hemorrhage during pregnancy. These conditions include, but are not limited to: placenta previa (when the placenta covers the cervix); placental abruption (when the placenta prematurely detaches from the uterine lining); placenta accreta (when the placenta grows into the uterine wall); uterine fibroids (that inhibit the uterus from contracting effectively and stopping bleeding from the placental implantation site); and other forms of first or second trimester bleeding.[18]

143. Severe forms of hypertension in pregnancy can also lead to life-threatening conditions. For example, preeclampsia is a complication of pregnancy which, when severe, can

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[16] *See Practice Bulletin 193: Tubal Ectopic Pregnancy*, ACOG (Mar. 2018), https://www.fertilehealthexpert.com/wp-content/uploads/2021/11/Ectopic-Pregnancy-ACOG.pdf.

[17] *SMFM Consult Series #63: Cesarian Scar Ectopic Pregnancy*, Soc'y for Maternal Fetal Med. (Sept. 2022), https://www.smfm.org/publications/448-smfm-consult-series-63-cesarean-scar-ectopic-pregnancy#:~:text=Cesarean%20scar%20ectopic%20pregnancy%20is,in%20securing%20a%20prompt%20diagnosis.

[18] *See Practice Bulletin 222: Gestational Hypertension and Preeclampsia*, ACOG (June 2020), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/06/gestational-hypertension-and-preeclampsia; *Practice Bulletin 203: Chronic Hypertension in Pregnancy*, ACOG (Jan. 2019), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2019/01/chronic-hypertension-in-pregnancy.

cause seizures, injury to the pregnant person's liver and kidneys, stroke, and death. HELLP (Hemolysis, Elevated Liver Enzymes and Low Platelets) syndrome is a particularly dangerous variant of preeclampsia. For some patients, other forms of hypertension (sometimes in conjunction with other chronic conditions like obesity and diabetes) can increase in severity and cause the same complications seen with severe preeclampsia.

144. Infection of the reproductive organs, which can lead to chorioamnionitis (infection of the placenta or amniotic fluid) or sepsis (where the body's response to infection damages its own tissue), is another risk that can cause a pregnant person's medical condition to become emergent. Premature dilation of the cervix, for example, dramatically increases a pregnant person's risk of infection and can be caused by conditions like an incompetent cervix (weak cervical tissue) and/or PPROM before the onset of labor. PPROM has a relatively high incidence, occurring in approximately 2% to 3% of pregnancies in the United States, and is an emergent condition itself due to the high risk of infection it entails.[19]

145. Other medical conditions can become emergent during pregnancy, either because being pregnant causes or exacerbates a chronic condition or increases other health risks, or because treatment for the chronic condition is unsafe while pregnant. For example: certain cancers requiring radiation, chemotherapy, or major surgery; certain cardiac, autoimmune, respiratory, or endocrine diseases; certain cases of hyperemesis gravidarum; and certain psychiatric conditions like bipolar disorder, major depressive disorder, anxiety disorders, and psychotic disorders can all be emergent, depending on the circumstances. Intentional acts of violence or accidents, e.g., motor vehicle crashes, firearm violence, intimate partner violence, etc., and substance use disorder can

[19] *See Practice Bulletin 217: Prelabor Rupture of Membranes*, ACOG (Mar. 2020), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/03/prelabor-rupture-of-membranes.

also lead to emergent conditions. Because each patient's circumstances are unique, it is within the purview of the patient's medical provider to determine whether the patient's comorbidities and/or other circumstances make abortion part of the patient's recommended course of treatment.[20]

146. Finally, certain fetal conditions or diagnoses can increase the risks to a pregnant person's health such that, when combined with the patient's other comorbidities, her medical provider may determine that an abortion is necessary or recommended to prevent serious jeopardy to the pregnant person's health.

147. For example, neural tube defects (including anencephaly); certain trisomies like trisomy 13 and 18 (the presence of an extra chromosome); triploidy (the presence of an extra set of chromosomes); certain gastric and cardiac defects in the fetus; and Potter Syndrome (where the fetus does not properly develop kidneys), are examples of conditions where the fetus either will not survive delivery or likely will not survive more than a few hours or days after birth. As in Lauren M.'s case, cystic hygromas may indicate the presence of one or more of these fetal conditions. Abortion is generally indicated for patients with such pregnancies, as abortion is typically medically safer for the pregnant person than carrying the pregnancy to term and delivering a baby with no meaningful chance of survival.

148. Some fetal conditions present particularly acute risks to the pregnant person. For example, partial molar pregnancy is a condition where the placenta transforms into an invasive cancer, thus creating an emergency for the pregnant person. Mirror syndrome is an emergent

[20] *See High-Risk Pregnancy*, Cleveland Clinic, https://my.clevelandclinic.org/health/diseases/22190-high-risk-pregnancy (Last Updated Dec. 14, 2021) (describing how certain preexisting conditions exacerbate the risks of the pregnancy); *Practice Bulletin 189: Nausea and Vomiting of Pregnancy*, ACOG (Jan. 2018), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/01/nausea-and-vomiting-of-pregnancy; Nicole T. Christian & Virginia F. Borges, *What* Dobbs *Means for Patients with Breast Cancer*, 387 N. Engl. J. Med. 765-67 (Sept. 1, 2022).

complication of pregnancy where the pregnant person and fetus both experience severe fluid retention that can lead to both fetal and maternal demise.

149. In the case of multiple pregnancies (twins, triplets, etc.) a fetal condition in one or more of the fetuses, combined with the pregnant person's other comorbidities, can lead to an emergent condition where selective abortion (sometimes called selective "fetal reduction" or "fetal termination") of one (or more) fetus is necessary to give the pregnant person and the remaining fetus(es) the best chance of survival.[21]

150. The discussion above highlights some of the emergent medical conditions necessitating prompt abortion care, but the list is by no means exhaustive, nor could it be. Mainstream medical associations emphasize that physician discretion to diagnose and treat emergent conditions is paramount to patient health.

151. Thus, where state law seeks to create a statutory exception to its abortion ban to allow abortion care for the purpose of preserving the life or health (including fertility) of the pregnant person, it must recognize that it is within the purview of the medical provider to determine the appropriate course of treatment for the patient. When a physician determines that such treatment includes abortion, the physician must be able to provide that treatment without concern that a prosecutor, jury, or disciplinary board second guessing their medical judgment will send them to prison and/or revoke their medical license.

152. The nature of abortion as critical health care is all the more acute in Texas, where maternal mortality and morbidity rates are rising. Texas's Maternal Mortality and Morbidity

[21] *Practice Bulletin 231: Multifetal Gestations Twin Triplet and Higher-Order Multifetal Pregnancies*, ACOG (June 2021), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2021/06/multifetal-gestations-twin-triplet-and-higher-order-multifetal-pregnancies.

Review Committee and the Department of State Health Services recently released their joint biennial report, and the results are shocking and alarming:

153. Among the documented pregnancy related deaths in Texas, a staggering 90% were preventable.[22]

154. According to the report, the maternal mortality ratio for Texas is higher than the national average—20.2 maternal deaths per 100,000 live births (in 2017, the latest year with available data), compared to the national average of 17.4 deaths per 100,000 live births (in 2018, the closest year for which data is available).[23]

155. The report finds that the leading cause of pregnancy-related deaths in Texas was obstetric hemorrhage, and the leading underlying causes of hemorrhage were ruptured ectopic pregnancy, uterine rupture, placental abruption, and placenta accreta—all conditions which are considered emergent. In 2019, at least 13 women in Texas died from a ruptured ectopic pregnancy.[24]

156. The report shows that Severe Maternal Morbidity (SMM)—defined as "unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health" that "if left untreated, could result in death"—increased significantly between 2018 to 2020, surging from 58.2 to 72.7 cases per 10,000 delivery hospitalizations. The total rate of pregnancy-related illnesses and injuries is likely much higher, as the SMM rate only captures

[22] Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report 2022 ("Texas MMRC 2022 Report") at 8, https://www.dshs.texas.gov/sites/default/files/legislative/2022-Reports/Joint-Biennial-MMMRC-Report-2022.pdf

[23] *Id.* at 10; *Maternal Mortality Rates in the United States*, Ctrs. for Disease Control & Prevention, https://www.cdc.gov/nchs/data/hestat/maternal-mortality-2021/maternal-mortality-2021.htm.

[24] Texas MMRC 2022 Report at 8.

the most severe events (life threatening conditions or life-saving medical procedures) that occur in specific contexts (in hospitals when a patient delivers).[25]

157. Between 2017 and 2020, SMM rates related to sepsis doubled, and SMM rates related to preeclampsia rose by 37% over the same time period.[26]

158. The report also finds significant demographic and geographic disparities in maternal mortality and morbidity, particularly among non-Hispanic Black women, who are twice as likely as white women and four times as likely as Hispanic women to die from pregnancy-related causes.[27]

159. Racial and ethnic disparities in pregnancy-related health outcomes are well-documented throughout the medical literature. Research has shown that, as compared to non-Hispanic white women, Black women in the U.S. are considerably more likely to experience obstetric complications like hypertensive disorders and preterm birth and to die from complications like preeclampsia, eclampsia, obstetric embolism, hemorrhage, and postpartum cardiomyopathy.[28] Additionally, Black people in the United States are more likely to have preexisting conditions that may be exacerbated by pregnancy such as high blood-pressure, asthma, diabetes, sickle cell disease, and lupus.[29]

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[25] *Id.* at 10-11.

[26] *Id.* at 8-12.

[27] *Id.* at 10.

[28] *CDC Press Release: Hypertensive Disorders in Pregnancy Affect 1 in 7 Hospital Deliveries*, Ctrs. for Disease Control & Prevention (Apr. 28, 2022), https://www.cdc.gov/media/releases/2022/p0428-pregnancy-hypertension.html; *Preterm Birth*, Ctrs. for Disease Control & Prevention (Nov. 1, 2022), https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm; Marian F. MacDorman, *Racial and Ethnic Disparities in Maternal Mortality in the United States Using Enhanced Vital Records, 2016–2017*, 111(9) Am. J. Publ. Health 1673, 1676 (2021), https://doi.org/10.2105/AJPH.2021.306375; *see also* Texas MMRC 2022 Report at 11-12.

[29] *Facts About Hypertension*, Ctrs. for Disease Control & Prevention (Jan. 5, 2023), https://www.cdc.gov/bloodpressure/facts.htm; Cynthia A. Pate et al., *Asthma Surveillance — United States, 2006–2018*, 70(5) Morbidity & Mortality Weekly Report 1, https://www.cdc.gov/mmwr/volumes/70/ss/

160. The Texas Maternal Mortality Report further notes that "delay in referring or access to treatment," "lack of standardized policies/procedures," "failure to screen/inadequate assessment of risk," "lack of continuity of care," and "lack of access/financial resources" are all contributing factors in maternal deaths in Texas.[30]

161. Barriers such as these disproportionately impact Black patients. Black patients face significant barriers to quality, equitable health care, including delays in care, systemic discrimination, and implicit biases in their interactions with health care providers.[31] Black women in Texas also face disproportionate poverty: 19.5% of Black Texans lives in poverty compared to 10.5% of white Texans. And 15.5% of Texan women live in poverty compared to 13% of Texan men.[32] This, coupled with Texas's restrictive Medicaid and insurance coverage policies, renders health care unaffordable for many.[33]

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ss7005a1.htm?s_cid=ss7005a1_w; *The Facts, Stats, and Impacts of Diabetes*, Ctrs. for Disease Control & Prevention (Jun. 20, 2022), https://www.cdc.gov/diabetes/library/spotlights/diabetes-facts-stats.html; *Data & Statistics on Sickle Cell Disease*, Ctrs. for Disease Control & Prevention (May 2, 2022), https://www.cdc.gov/ncbddd/sicklecell/data.html; Maria Dall'Era, *Systemic Lupus Erythematosus*, in John B. Imboden et al., (eds), Current Rheumatology Diagnosis and Treatment 3rd ed, New York, NY: McGraw-Hill (2013).

[30] Texas MMRC 2022 Report at D-2, D-3. In fact, a report by March of Dimes found that 49.2% of Texas counties are "maternity care deserts" where maternity health services are entirely absent. It also found that an additional 22.8% of Texas counties have only low or moderate access where there are few hospitals or birth centers, few obstetric care providers, or a high proportion of women without insurance coverage. *Maternity Care Desert: Texas, 2020*, March of Dimes (last visited Mar. 2, 2023), https://www.marchofdimes.org/peristats/data?reg=99&top=23&stop=641&lev=1&slev=4&obj=9&sreg=48.

[31] Michael T. Halpern & Debra J. Holden, *Disparities in Timeliness of Care for U.S. Medicare Patients Diagnosed with Cancer*, 19(6) Current Oncology e404-13 (2012); Jasmine M. Miller-Kleinhenz et al., *Racial Disparities in Diagnostic Delay Among Women with Breast Cancer*, 18(10) J. Am. Coll. Radiol. 1384 (2021); Joe Feagin & Zinobia Bennfield, *Systemic Racism and U.S. Health Care*, 103 Soc. Sci. & Med. 7 (2013); Bani Saluja & Zenobia Bryant, *How Implicit Bias Contributes to Racial Disparities in Maternal Morbidity and Mortality in the United States*, 30(2) J. Women's Health 270-273 (2021); Brenda Pereda & Margret Montoya, *Addressing Implicit Bias to Improve Cross-Cultural Care*, 61 Clinical Obstetrics & Gynecology 2, 3-5 (2018).

[32] *American Community Survey S107: Poverty Status in the Past 12 Months*, United States Census Bureau (last visited Mar. 1, 2023), https://data.census.gov/table?q=gender+poverty+in+texas.

[33] *The State of Reproductive Health and Rights: A 50-State Report Card*, Population Institute (Feb. 2021), https://www.populationinstitute.org/resource/the-state-of-reproductive-health-and-rights-a-50-state-report-card.

162. The Texas Maternal Mortality Report ends with multiple recommendations that are at odds with the demonstrated impact of Texas's abortion bans. For example: "[p]romote patient-centered care through shared decision-making recognizing women as experts in their values and preferences and supporting informed, collaborative approaches to making health care decisions"; "support health systems with implementing evidence-based standards, guidelines, and practices, increasing patient and family engagement, promoting health care quality improvement, and reducing maternal health disparities"; "[s]upport emergency and maternal health service coordination" as "[e]mergency health providers' knowledge about maternal health, as well as communication and coordination with obstetric and women's health professionals, are critical factors in preventing pregnancy-related deaths."[34]

C. Texas's Abortion Bans

163. Texas has several abortion bans relevant to Amanda, Lauren M., Lauren H., Anna, Ashley, and the Physician Plaintiffs and their patients.

1. Texas's Definition of Abortion

164. Texas law does not define "abortion" using the medical definition. Rather, Texas law states: "'Abortion' means the act of using or prescribing an instrument, a drug, a medicine, or any other substance, device, or means with the intent to cause the death of an unborn child of a woman known to be pregnant. The term does not include birth control devices or oral contraceptives. An act is not an abortion if the act is done with the intent to: (A) save the life or preserve the health of an unborn child; (B) remove a dead, unborn child whose death was caused by spontaneous abortion; or (C) remove an ectopic pregnancy." Tex. Health & Safety Code § 245.002(1).

[34] Texas MMRC 2022 Report at 16, 17, 20.

165. Texas law defines "ectopic pregnancy" as "the implantation of a fertilized egg or embryo outside of the uterus." Tex. Health & Safety Code § 245.002(4-a).

166. While there is no express definition, it is generally understood that in the context of Texas's definition of abortion, "dead" means that there is no cardiac activity present in the embryo or fetus. *See, e.g.*, Tex. Health & Safety Code §§ 171.201-203 (emphasizing importance of a "fetal heartbeat" or "cardiac activity" to "unborn life").

167. Abortions done to "save the life or preserve the health of *an* unborn child" are not considered abortions under Texas law. Tex. Health & Safety Code § 245.002(1)(A) (emphasis added); *see also* Tex. Health & Safety Code § 170A.002(b) (applying exception to abortion ban where "the person performs, induces, or attempts the abortion in a manner that, in the exercise of reasonable medical judgment, provides the best opportunity for the unborn child to survive unless, in the reasonable medical judgment, that manner would create . . . a serious risk of substantial impairment of a major bodily function of the pregnant female.").

168. Texas's abortion bans cite back to Texas's definition of abortion, meaning that neither medical care involving removal of an ectopic pregnancy, nor removal of pregnancy tissue where no cardiac activity is present, is an abortion under Texas law.

2. Trigger Ban

169. Texas's criminal ban on abortion is often referred to as the Trigger Ban because, while signed into law in 2021, it specified a contingent effective date and did not take effect until August 25, 2022, 30 days after the Supreme Court issued its judgment overturning *Roe v. Wade*.[35]

[35] Defendant Paxton published an "Advisory on Texas Law" after the U.S. Supreme Court issued its opinion in *Dobbs v. Jackson Women's Health Org.*, Case No. 19-1392, on June 24, 2022, that correctly noted the effective date of the Trigger Ban as 30 days after issuance of the "judgment" in *Dobbs*. Ken Paxton, Tex. Att'y Gen., *Advisory on Texas Law Upon Reversal of* Roe v. Wade (June 24, 2022), https://www.texasattorneygeneral.gov/sites/default/files/images/executive-management/Post-Roe%20Advisory.pdf. Defendant Paxton later published an "Updated Advisory on Texas Law" upon issuance of the *Dobbs* judgment that confirmed that the Trigger Ban would

170. The Trigger Ban states that "[a] person may not knowingly perform, induce, or attempt an abortion," citing to Texas's longstanding definition of abortion. Tex. Health & Safety Code §§ 170A.001(a), 170A.002(a).

171. There are both criminal and civil penalties for violations of the Trigger Ban.

172. A person can be charged with either a first- or second-degree felony for violating the Trigger Ban. Tex. Health & Safety Code §§ 170A.004. First-degree felonies are subject to imprisonment for life, or a term of between 5 and 99 years. Tex. Penal Code §12.32. Second-degree felonies are punishable by imprisonment for a term of between 2 and 20 years. Tex. Penal Code §12.33.

173. Further, the Trigger Ban states that the relevant licensing authority, the Texas Medical Board, "shall revoke the license, permit, registration, certificate, or other authority of a physician or other health care professional who performs, induces, or attempts an abortion in violation" of the Trigger ban. Tex. Health & Safety Code § 170A.007.

174. Finally, any person who violates the Trigger Ban "is subject to a civil penalty of not less than $100,000 for each violation," and "[t]he attorney general shall file an action to recover a civil penalty assessed under this section and may recover attorney's fees and costs incurred in bringing the action." Tex. Health & Safety Code § 170A.005.

175. The only exception to the Trigger Ban is an abortion performed by a physician on a patient with an emergent medical condition (*see infra* ¶ 187).

take effect August 25, 2022. Ken Paxton, Tex. Att'y Gen., *Updated Advisory on Texas Law Upon Reversal of* Roe v. Wade (July 27, 2022), https://texasattorneygeneral.gov/sites/default/files/images/executive-management/Updated%20Post-Roe%20Advisory%20Upon%20Issuance%20of%20Dobbs%20Judgment%20(07.27.2022).pdf

3. Senate Bill 8

176. Senate Bill 8 of 2021 prohibits physicians from providing an abortion in Texas if the embryo or fetus has detectible cardiac activity. Tex. Health & Safety Code §§ 171.201-204. S.B. 8 took effect in September of 2021 and creates additional civil penalties for physicians who perform abortions prohibited by S.B. 8.

177. Violations of S.B. 8 are subject to a bounty-hunting civil enforcement scheme allowing any individual to seek "statutory damages in an amount of not less than $10,000 for each abortion that the defendant performed" and "injunctive relief sufficient to prevent the defendant from violating" S.B. 8 in the future. Tex. Health & Safety Code §§ 171.207-211.

178. Like the Trigger Ban, the only exception to S.B. 8's ban on abortion in pregnancies with detectible cardiac activity is an abortion performed by a physician on a patient with an emergent medical condition (discussed in detail below).

179. S.B. 8 also created new state documentation and reporting requirements that apply to all abortions performed under the Emergent Medical Condition Exception. As of September 1, 2021, all abortions performed under the Emergent Medical Condition Exception must be documented in detail by the treating physician. Specifically, the physician must "execute a written document": (1) that "certifies the abortion is necessary due to a medical emergency;" (2) that "specifies the medical condition the abortion is asserted to address;" (3) that "provides the medical rationale for the physician's conclusion that the abortion is necessary to address the medical condition;" (4) "place the document . . . in the pregnant woman's medical record" (5) and "maintain a copy of the document . . . in the physician's practice records." Tex. Health & Safety Code §§ 171.008, 171.205.

180. S.B. 8 also requires physicians who perform abortions at abortion facilities to report all abortions performed under the Emergent Medical Condition Exception to the state. Tex. Health

& Safety Code § 245.011(c)(10), (11) (requiring reporting to include "whether the abortion was performed or induced because of a medical emergency and any medical condition of the pregnant woman that required the abortion").

*4. Pre-*Roe *Ban*

181. The Texas abortion ban at issue in *Roe v. Wade* (the "pre-*Roe* Ban")[36] also contained an exception for the life of the pregnant person.[37] After the pre-*Roe* ban was held unconstitutional in 1973, it was removed from the Texas Penal Code and Texas Civil Code. The Texas Legislature then enacted a comprehensive statutory scheme permitting and regulating abortion. In light of those later enactments, the Fifth Circuit held that the pre-*Roe* ban was impliedly repealed. *McCorvey v. Hill*, 385 F.3d 846 (5th Cir. 2004).[38]

182. On June 24, 2022, for the first time, the text of the pre-*Roe* Ban was placed on the Texas Legislature's website, with the note that the relevant statutes were "held to have been impliedly repealed in *McCorvey v. Hill*, 385 F.3d 846 (5th Cir. 2004)."[39] Despite that holding and subsequent litigation regarding the pre-*Roe* Ban, Defendant Paxton took the position that the pre-*Roe* Ban was immediately enforceable after *Roe v. Wade* was overturned. Courts addressing this

[36] "If any person shall designedly administer to a pregnant woman or knowingly procure to be administered with her consent any drug or medicine, or shall use towards her any violence or means whatever externally or internally applied, and thereby procure an abortion, he shall be confined in the penitentiary not less than two nor more than five years; if it be done without her consent, the punishment shall be doubled. By "abortion" is meant that the life of the fetus or embryo shall be destroyed in the woman's womb or that a premature birth thereof be caused." 1925 Tex. Crim. Stat. 1191.

[37] "By medical advice. Nothing in this chapter applies to an abortion procured or attempted by medical advice for the purpose of saving the life of the mother." 1925 Tex. Crim. Stat. 1196.

[38] *See also Whole Woman's Health v. Paxton*, Civil Cause No. 2022-38397, 2022 WL 2314499 (Harris Cnty. Dist. Ct. June 27, 2022), *injunction lifted by In re Paxton*, No. 22-0527, 2022 WL 2425619 (Tex. July 1, 2022), *case dismissed* (Harris Cnty. Dist. Ct. Oct. 5, 2022); *Texas v. Becerra*, No. 5:22-cv-185-H, 2022 WL 3639525 (N.D. Tex. Aug. 23, 2022), *appeal docketed*, No. 22-11037 (5th Cir. Oct. 25, 2022); Order, *Fund Tex. Choice v. Paxton*, No. 1:22-cv-00859 (W.D. Tex. Feb. 24, 2023), ECF No. 120.

[39] Vernon's Tex. Civ. Stats. ch. 6-1/2 (last updated Dec. 14, 2022), https://statutes.capitol.texas.gov/Docs/SDocs/VERNON'SCIVILSTATUTES.pdf.

issue after *Roe* was overturned, however, largely disagree. *See* Order at 1, *Fund Tex. Choice v. Paxton*, No. 1:22-CV-859-RP (W.D. Tex. Feb. 24, 2023), ECF No. 120 ("[T]he Court finds that the pre-*Roe* laws have been repealed by implication . . . ."); *Texas v. Becerra*, No. 5:22-CV-185-H, 2022 WL 3639525, at *2 (N.D. Tex. Aug. 23, 2022) (treating the pre-Roe ban as enforceable but noting that the Trigger Ban "reflects a more recent, more specific regulation of abortion and, normally, a more recent enactment governing the same subject supersedes prior enactments").

D. Exception to Texas's Abortion Bans for Emergent Medical Conditions

183. Texas's abortion laws have long recognized that providing abortion care to pregnant people with emergent medical conditions is exempted from the state's various restrictions on the provision of abortion. Yet inconsistencies in the language of these provisions, the use of non-medical terminology, and sloppy legislative drafting have resulted in understandable confusion throughout the medical profession regarding the scope of the exception.

1. History of the Emergent Medical Condition Exception

184. Texas's Emergent Medical Condition Exception first appeared in the Texas code in 2011, when Texas updated its informed consent requirements for abortion and created certain exceptions for cases of so-called "medical emergency." It defined "medical emergency" as "a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed." Tex. Health & Safety Code § 171.002(3) (hereinafter the "Definition Provision").

185. Over the last ten years, Texas has added numerous requirements to its abortion code that, utilizing this definition, have exceptions for "medical emergencies."[40] For example, in 2017 Texas passed a ban on "dismemberment abortion"—essentially a ban on dilation and evacuation (D&E) abortions—that has an exception for "medical emergencies." Tex. Health & Safety Code § 171.152(a).

186. S.B. 8 is another example. The only exception to S.B. 8's abortion ban and its associated civil penalties is for patients where "a physician believes a medical emergency exists." Tex. Health & Safety Code § 171.205.

187. The same language in the Definition Provision appears as the sole exception to the Trigger Ban. Specifically, Texas's criminal ban on abortion "does not apply if: (1) the person performing, inducing, or attempting the abortion is a licensed physician; (2) in the exercise of reasonable medical judgment, the pregnant female on whom the abortion is performed, induced, or attempted has a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that places the female at risk of death or poses a serious risk of substantial impairment of a major bodily function unless the abortion is performed or induced; and (3) the person performs, induces, or attempts the abortion in a manner that, in the exercise of reasonable medical judgment, provides the best opportunity for the unborn child to survive unless, in the reasonable medical judgment, that manner would create: (A) a greater risk of the pregnant female's death; or (B) a serious risk of substantial impairment of a major bodily function of the pregnant female." Tex. Health & Safety Code § 170A.002(b).

[40] *See* Tex. Health & Safety Code § 171.0124 (informed consent); Tex. Fam. Code §§ 33.002, 33.0022 (informed consent for minors); Tex. Ins. Code §§ 1218.001, 1696.001 (insurance coverage); Tex. Gov't Code § 2273.002 (facility licensing); Tex. Health & Safety Code § 171.152(a) (ban on "dismemberment abortions"); Tex. Occ. Code § 164.052 (physician licensing).

2. Physician Discretion Under the Emergent Medical Condition Exception

188. Courts have long recognized that where an abortion ban provides an exception for patients in certain circumstances, a good faith standard, rather than a reasonable person standard, must apply. *See, e.g.*, *Colautti v. Franklin*, 439 U.S. 379, 395-96 (1979) ("Because of the absence of a scienter requirement in the provision directing the physician to determine whether the fetus is or may be viable, the statute is little more than 'a trap for those who act in good faith'" (quoting *United States v. Ragen*, 314 U.S. 513, 524 (1942))); *Women's Med. Prof'l Corp. v. Voinovich*, 130 F.3d 187, 205 (6th Cir. 1997) ("The determination of whether a medical emergency or necessity exists . . . is fraught with uncertainty and susceptible to being subsequently disputed by others. . . . In an area as controversial as abortion, . . . where there is such disagreement, it is unlikely that the prosecution could not find a physician willing to testify that the physician did not act reasonably. Under the Act, a physician who performs a post-viability abortion under either the medical emergency or medical necessity exception may be held liable, even if the physician believed he or she was acting reasonably, and in accordance with his or her best medical judgment, as long as others later decide that the physician's actions were nonetheless unreasonable.").

189. The Emergent Medical Condition Exception's language, which appears five times in the Texas abortion code, contains conflicting language across the different sections regarding physician discretion and intent. This leaves physicians uncertain whether the treatment decisions they make in good faith, based on their medical judgment, will be respected or will be later disputed.

190. For example, the Trigger Ban defines "reasonable medical judgment" as "a medical judgment made by a reasonably prudent physician, knowledgeable about a case and the treatment possibilities for the medical conditions involved." Tex. Health & Safety Code § 170A.001(4).

191. Yet the Trigger Ban also prohibits a physician from "knowingly" providing a prohibited abortion. Thus, a physician does not violate the Trigger Ban by providing an abortion in reliance on the exception unless the physician subjectively *knows* that in the exercise of reasonable medical judgment, the patient does *not* have a condition qualifying for the exception. When a physician relies on the exception in good faith, the physician does not know that the exception does not apply. Stated differently, a physician cannot knowingly violate the ban if she acts in good faith reliance on the exception.

192. Meanwhile, the Definition Provision's language, which applies to S.B. 8, does not explicitly mention intent. Instead, the language "as certified by a physician" modifies the exception language, suggesting that the treating physician's good faith certification, buttressed by the documentation and reporting requirements for medical emergencies added to the code by S.B. 8, governs the assessment of a patient's circumstances.

193. Physicians confronted with the question of whether or not a patient qualifies for the Emergent Medical Condition Exception must consider not only their ethical responsibilities as physicians and potential medical malpractice liability if they do not follow the standard of care, but the risk of loss of liberty and prison sentence they will face, Tex. Health & Safety Code § 170A.004, Tex. Penal Code §§ 12.32-.33, and the potential loss of their license to practice medicine and pursue their chosen profession if they are found guilty of violating an abortion ban, Tex. Occ. Code §§ 165.001, 164.052(a)(5), 164.053(a), 164.055; Tex. Health & Safety Code § 170A.007.

194. Understandable confusion regarding physicians' level of discretion under Texas's abortion bans and fear for the legal consequences if they are wrong, is leading to physicians denying care to patients—including patients presenting with emergent conditions—even when

such care likely would fall within the exception. As Plaintiffs' experiences show, because of the laws' uncertainty, physicians are over-complying with the laws to the detriment of their patients' lives and health.

195. Texas has failed to provide clarification or guidance on the meaning of the exception, despite being asked repeatedly. *See infra* ¶¶ 215-26.

196. Texas's abortion bans can and should be read to ensure that physicians have wide discretion to determine the appropriate course of treatment, including abortion care, for their patients who present with emergent medical conditions—without being second guessed by the Attorney General, the Texas Medical Board, a prosecutor, or a jury.

3. Conditions Included in the Emergent Medical Condition Exception

197. In addition to the conflicting language regarding physician intent, Texas law provides scant guidance for what the rest of the language in the Emergent Medical Condition Exception means. Nowhere in the code does Texas law define any of the following distinctions: "risk" versus "serious risk"; "insubstantial impairment" versus "substantial impairment"; "minor bodily function" versus "major bodily function." Nor does Texas law define what it means to have "a serious risk of a substantial impairment" or "a substantial impairment of a major bodily function."

198. None of this terminology has standardized meaning in the medical profession, leaving physicians to guess at how to translate it into clinical practice. The lack of clarity is preventing medical professionals from providing the care that their patients need.

199. The best reading of Texas law's plain text in the context of supporting patient and physician autonomy requires, at a minimum, that: 1) measurement of risk is left to physician judgment 2) impairment of a "major bodily function" includes harm to reproductive functions and

fertility 3) acute risk need not be already present or imminent; and 4) the patient's condition need not be presently "life-threatening."

200. A condition placing the pregnant person at "risk" or "serious risk" includes any condition that, in the physician's judgment, merits intervention to prevent "death" or "substantial impairment of a major bodily function," given the patient's symptoms, medical history, and the physician's experience and training.

201. While "major bodily function" is not defined in the Texas Health and Safety Code, the Texas Labor Code defines the term to include "reproductive functions." Tex. Labor Code § 21.002(11-a) ("[M]ajor bodily function, includ[es], but [is] not limited to, functions of the immune system, normal cell growth, and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.").

202. Accordingly, any physical condition that presents a serious risk of substantially impairing the patient's future fertility falls within the exception. This includes any condition that poses a serious risk of substantial impairment or loss of the patient's uterus, ovaries, or other reproductive organs.

203. The exception does not require that any of the risks to the pregnant person be imminent. To the contrary, the exception only requires that a physician certify that the patient is "in danger of death" *or* has a condition that creates "a serious risk of substantial impairment of a major bodily function."

204. Nor does the best reading of the exception require that the pregnant person have a condition that is imminently and/or definitively "life-threatening." While the exception references a "life-threatening physical condition," this phrase must be read together with the full language of the exception, which permits physicians to provide an abortion if the patient's condition would

pose a serious risk to her health (specifically, a "serious risk of substantial impairment of a major bodily function") if left untreated.

205. The Trigger Ban states that the Emergent Medical Condition Exception does not apply to abortions performed to prevent a pregnant person from harming themself: "A physician may not" provide an abortion "if, at the time the abortion was performed, induced, or attempted, the person knew the risk of death or a substantial impairment of a major bodily function described by [the Emergent Medical Condition Exception] arose from a claim or diagnosis that the female would engage in conduct that might result in the female's death or in substantial impairment of a major bodily function." Tex. Health & Safety Code § 170A.002(c). The Definition Provision (and thus S.B. 8) does not contain the same carve out.

206. Notwithstanding the Definition Provision's use of the term "medical emergency," the language of the exception—which also appears in the Trigger Ban without the use of the term "medical emergency"—is broader than the type of medical conditions that physicians would consider "emergencies" under, for example, the Emergency Medical Treatment & Labor Act ("EMTALA").[41]

207. An analysis of Texas's Emergent Medical Condition Exception and similar exceptions in other states' abortion bans shows that Texas's language is comparatively broad. Some states do not contain "emergency" exceptions at all, but only provide affirmative defenses to be used in prosecutions.[42] Some states do not explicitly exclude ectopic pregnancies and/or treatment for miscarriage from their definitions of abortion.[43] Some states mention "impairment

[41] *See* 42 U.S.C. § 1395dd(e)(1) (defining medical emergency to involve, among other things, "acute symptoms of sufficient severity (including severe pain)" that create a need for "immediate medical attention").

[42] *See, e.g.*, Idaho Code § 18-622(3); N.D. Cent. Code § 12.1-31-12; Tenn. Code § 39-15-213(c).

[43] *See, e.g.*, Mo. Rev. Stat. § 188.015(1); Miss. Code § 41-41-45(1); Tenn. Code § 39-15-213(a)(1).

of a major bodily function" but require such impairment to be "irreversible" in addition to "substantial," while other states limit their exception to life-threatening conditions.[44] And some states require a second physician to confirm that an exception applies.[45]

208. Reading the provisions of the Emergent Medical Condition Exception together, they permit physicians to provide an abortion to a patient where, in the physician's good faith judgment, the patient has a physical condition posing a risk of death or a serious risk to the patient's health. Such conditions include, but are not limited to, the following: conditions that can lead to dangerous bleeding or hemorrhage, including placental conditions; dangerous forms of hypertension; conditions that can lead to dangerous infection, including premature rupture of membranes; other medical conditions that can become emergent during pregnancy, either because being pregnant causes or exacerbates a chronic condition or increases other health risks, or because

[44] *See, e.g.*, Ark. Code § 5-61-303(3) ("'Medical emergency' means a condition in which an abortion is necessary to preserve the life of a pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself."); Ky. Rev. Stat. § 311.772(4)(a) (An abortion may be performed "to prevent the death or substantial risk of death due to a physical condition, or to prevent the serious, permanent impairment of a life-sustaining organ of a pregnant woman."); Okla. Stat. tit. 63, § 1-731.4(A)(2) ("'Medical emergency' means a condition which cannot be remedied by delivery of the child in which an abortion is necessary to preserve the life of a pregnant woman whose life is endangered by a physical disorder, physical illness or physical injury including a life-endangering physical condition caused by or arising from the pregnancy itself."); La. Stat. § 40:1061(F) (Abortion may be performed where "necessary in reasonable medical judgment to prevent the death or substantial risk of death due to a physical condition, or to prevent the serious, permanent impairment of a life-sustaining organ of a pregnant woman."); Miss. Code § 41-41-45(2) ("No abortion shall be performed or induced in the State of Mississippi, except in the case where necessary for the preservation of the mother's life."); Mo. Rev. Stat. § 188.015(7) ("'Medical emergency,' a condition which, based on reasonable medical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert the death of the pregnant woman or for which a delay will create a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman."); S.D. Codified Laws § 22-17-5.1 (Abortion prohibited "unless there is appropriate and reasonable medical judgment that performance of an abortion is necessary to preserve the life of the pregnant female."); Tenn. Code § 39-15-213(c)(2) (An abortion may be performed where "the abortion was necessary to prevent the death of the pregnant woman or to prevent serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman."); Utah Code § 76-7a-201(1)(a) (An abortion may be performed where "necessary to avert: (i) the death of the woman on whom the abortion is performed; or (ii) a serious risk of substantial and irreversible impairment of a major bodily function of the woman on whom the abortion is performed."); H.B. 481 sec. 4(2), 2019 Leg., Reg. Sess. (Ga. 2019) ("'Medical emergency' means a condition in which an abortion is necessary in order to prevent the death of the pregnant woman or the substantial and irreversible physical impairment of a major bodily function of the pregnant woman.").

[45] *See, e.g.*, Ala. Code § 26-23H-4; Utah Code § 76-7a-201(1)(b).

treatment for the chronic condition is unsafe while pregnant (with the exception of conditions whose emergent nature stems from the risk of self-harm, which are statutorily excluded); and certain fetal conditions or diagnoses that can increase the risks to a pregnant person's health such that, when combined with the patient's other comorbidities, a patient's medical provider may determine that the patient has an emergent condition necessitating abortion.[46]

4. Legislative Intent Regarding the Scope of the Emergent Medical Condition Exception

209. In interpreting the Emergent Medical Condition Exception language, the intent of the legislature and lawmakers who make and enforce Texas's abortion bans, while sparce, is instructive.

210. In 2021, Senator Angela Paxton was the primary sponsor of the Trigger Ban in the Senate. During a debate on the Senate floor regarding the bill, Senator Paxton explained to her Senate colleagues that it "would be the determination of the physician and the woman" whether or not the woman has "a physical condition" that meets the requirements of the Emergent Medical Condition Exception.[47]

211. In 2013, then-Representative Jodie Laubenberg was one of the primary sponsors on a bill banning abortion after 20 weeks of pregnancy that also contained the Emergent Medical Condition Exception. The 20-week ban was ultimately passed into law as part of omnibus anti-abortion legislation, House Bill 2. During a debate on the House floor regarding House Bill 2, Representative Laubenberg explained to her House colleagues that the Bill "gives the physician full authority to know what condition his patient is in and to have that authority to make that

[46] Other emergent conditions, like ectopic pregnancy, are not included here because the necessary abortion care they require is explicitly excluded from Texas's definition of abortion. *See supra* ¶¶ 164-65.

[47] *Senate Session*, 87th Leg., Reg. Sess. (Tex. Mar. 29, 2021) (floor debate on Senate Bill 9, the companion bill to House Bill 1280, the Trigger Ban), https://tlcsenate.granicus.com/MediaPlayer.php?view_id=49&clip_id=15566 (beginning at 4:47:18).

determination."[48] She then repeated this understanding of what she described as a "very broad" exception *eight more times* during the floor debate.[49]

212. Representative Laubenberg also stated that she "would disagree" with a reading of the bill that blocked physicians from performing an abortion until "an infection has become so severe [that it poses an immediate risk of death]." Consistent with this position, she agreed that "toxemia" and "ruptured membranes" (PPROM) "would be covered under [the] exception."[50]

213. Yet the legislators who supported these bills and other politicians in Texas who championed them have largely remained silent since S.B. 8 took effect and *Roe* was overturned.

214. Meanwhile, confusion among the medical profession over the last year and a half regarding the scope and meaning of the exception has been widely reported, showing that Plaintiffs' experiences are the norm, not the exception.

215. Shortly after *Roe v. Wade* was overturned, the Texas Medical Association (TMA) asked state regulators to provide guidance to the state's physicians on the scope of the exception. Public reporting indicates that in July 2022, TMA sent a letter to the Texas Medical Board (TMB) saying it had received complaints that hospitals, administrators, and their attorneys are prohibiting doctors from providing abortion services to patients with major pregnancy complications for fear

[48] *House Session*, 83d Leg., 2d Called Sess., House Journal Suppl. S4–S6 (Tex. July 9, 2013) (floor debate on House Bill 2), https://journals.house.texas.gov/HJRNL/832/PDF/83C2DAY02SUPPLEMENTFINAL.PDF.

[49] *See id.* ("This bill does give the physician the full autonomy and full authority to take care of his patient."), *id.* (The exception language "places the physician at the center of this [determination]," so that "[i]t will be his judgment" whether the patient has met the threshold for an abortion under the exception.), *id.* (The bill "gives the physician full control" over determining whether the "threshold" for the emergent medical condition exception is met.), *id.* ("By this language, we're allowing whatever the physician determines to be the condition that would impair the physical life of the woman" to control.), *id.* ("[T]his language actually gives broad coverage by allowing the physician, the physician, to have that authority."), *id.* ("Actually, it's not [tying the physician's hands]" because "[i]t's very broad to give that physician the authority."), *id.* ("It's whatever the doctor believes is in the best interest for the health of the pregnant mom."), *id.* ("I would not want to limit the physician's authority.").

[50] *Id.*

of violating Texas's abortion bans. The letter, which is not public, is said to have asked the TMB to "swiftly act to prevent any wrongful intrusion into the practice of medicine."[51]

216. Upon information and belief, to date, the TMB has not responded to TMA.

217. Similarly, Texas Senator Bryan Hughes, the author of S.B. 8, sent a letter to the TMB on August 4, 2022, regarding reported complaints that hospitals "may be wrongfully prohibiting or seriously delaying physicians from providing medically appropriate and possibly life saving services to patients who have various pregnancy complications. These complaints arise from confusion or disregard of the law in Texas since [*Roe* was overturned] and must be corrected." Letter from Bryan Hughes to Executive Director Brint Carlton (Aug. 4, 2022) (attached hereto as Exhibit A).[52]

218. Senator Hughes's letter mentions many of the emergent medical conditions Plaintiffs argue are included in the Emergent Medical Condition Exception, and notes that his list is "non-exhaustive." Senator Hughes explicitly mentions PPROM, the same condition for which Amanda would be denied care three weeks later. *See* Ex. A at 1 n.3 ("[P]regnancy complication[s] that a physician could determine rise to the level of a 'medical emergency' are ectopic pregnancies, preterm premature rupture of membranes, pre-eclampsia, hemorrhaging, strain on the mother's heart, or peripartum cardiomyopathy. This is a non-exhaustive list.").

219. Senator Hughes's Letter concludes by saying "Texas law makes it clear that a mother's life and major bodily function should be protected." Ex. A at 2.

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[51] Allie Morris, *Texas Hospitals Fearing Abortion Law Delay Pregnant Women's Care, Medical Association Says*, Dallas Morning News (July 14, 2022), https://www.dallasnews.com/news/politics/2022/07/14/texas-hospitals-fearing-abortion-law-delay-pregnant-womens-care-medical-association-says/.

[52] The letter was made public in a news report regarding Texas's interpretation of EMTALA after *Roe* was overturned. Dan Vergano, *The Federal Law Against Patient Dumping—EMTALA—Is the Latest Front in the Abortion Battle*, Grid (Aug. 29, 2022), https://www.grid.news/story/science/2022/08/29/the-federal-law-against-patient-dumping-emtala-is-the-latest-front-in-the-abortion-battle.

220. Upon information and belief, to date, the TMB has not responded to Senator Hughes's letter.

221. In the months since, reporters have repeatedly asked Texas legislators to comment on accounts of specific pregnant people who have been denied emergent or emergency care due to the abortion bans. Upon information and belief, with only a couple exceptions, reporters have received no answer.

222. For example, CNN reporters writing a story about Amanda reached out to 28 state legislators for comment. Only one responded: State Senator Eddie Lucio, who left the Senate at the end of 2022. Senator Lucio provided the following quote to the reporters: "Like any other law, there are unintended consequences. We do not want to see any unintended consequences; if we do, it is our responsibility as legislators to fix those flaws."[53]

223. Representative Giovanni Capriglione, the primary sponsor of the Trigger Ban in the House, responded to a reporter's questions about exceptions to the ban by saying "if a qualified doctor, a physician *believes* that the pregnant mother's life is at risk, then they would be able to make a medical decision in that particular instance."[54]

224. When Governor Greg Abbott was asked about the Emergent Medical Condition Exception during his re-election campaign for governor, he said the following: "[S]omething that really does need to be done and that is clarify what it means to protect the life of the mother. There've been some comments and even maybe some actions by some doctors that are not taking care of women who have an ectopic pregnancy or who have a miscarriage. And that is wrong

[53] Elizabeth Cohen & John Bonifield, *Texas Woman Almost Dies Because She Couldn't Get an Abortion*, CNN (Nov. 16, 2022), https://www.cnn.com/2022/11/16/health/abortion-texas-sepsis/index.html.

[54] *Texas' 'Trigger Law' on Abortion Set to Go into Effect in 30 Days*, KLTV (June 24, 2022), https://www.kltv.com/2022/06/24/texas-trigger-law-abortion-set-go-into-effect-30-days/ (emphasis added).

because neither of those two are abortions. But that said, I've even seen some other situations that some women are going through where they're not getting the health care they need to protect their life. . . . [T]he point is this, our goal is to make sure we protect the lives of both the mother and the baby. And there's been too many allegations that have been made about ways in which the lives of the mother are not being protected. And so that must be clarified."[55]

225. Defendant Paxton sued Secretary of Health and Human Services Xavier Becerra over legal guidance that the Biden administration's HHS issued after *Roe v. Wade* was overturned. That guidance reiterated that the federal EMTALA law obligates hospitals and physicians to provide abortion care to a patient who presents to the hospital's emergency department if a physician or other qualified medical provider determines that the patient has an emergency medical condition and that an abortion is needed to prevent serious jeopardy to the patient's health. The guidance states that physicians and hospitals have a legal obligation to follow EMTALA even if doing so involves providing treatment—including abortion—that is prohibited in the state where the hospital is located. After receiving a preliminary injunction blocking part of the guidance in Texas, Paxton issued a press release lauding the decision, stating: "We're not going to allow left-wing bureaucrats in Washington to transform our hospitals and emergency rooms into walk-in abortion clinics" and "I will fight back to defend our pro-life laws and Texas mothers and children."[56]

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[55] Michael McCardel, *Race for Texas Governor: Full interview with Governor Greg Abbott*, WFAA (Oct. 16, 2022) at 1:42-2:26, https://www.wfaa.com/article/news/politics/inside-politics/texas-politics/inside-texas-politics-governor-greg-abbott-full-interview/287-e3aa0d2f-d204-46a9-8d4e-7dc442e5e6fa

[56] Ken Paxton, Tex. Att'y Gen., *Paxton Secures Victory Against Biden Administration, Blocks HHS from Forcing Healthcare Providers to Perform Abortions in Texas* (Aug. 24, 2022), https://www.texasattorneygeneral.gov/news/releases/paxton-secures-victory-against-biden-administration-blocks-hhs-forcing-healthcare-providers-perform.

226. As Plaintiffs' experiences show, Texas law is not "pro-life" when it comes to pregnant people's lives, and the State of Texas has failed to give physicians any meaningful guidance on how to interpret its laws consistent with that goal.

II. IN THE ABSENCE OF STATE GUIDANCE REGARDING THE EXCEPTION, TEXAS'S ABORTION BANS ARE HARMING PREGNANT PEOPLE WITH EMERGENT MEDICAL CONDITIONS AND THEIR PHYSICIANS

A. Impact of Texas' Abortion Bans on Pregnant People

227. Amanda, Lauren M., Lauren H., Anna, and Ashley's experiences are not isolated. Reports from around Texas reveal that pregnant people with emergent conditions are being denied appropriate counseling and abortion care in Texas altogether or are being forced to wait until they are clearly hemorrhaging or showing active signs of infection before they will be offered abortions. Each person's medical circumstances are unique, but in every case, Texas's abortion bans radically decreased the quality of their medical care during pregnancy, often with devastating results.

228. While some pregnant people have only shared their stories anonymously, many have used their names:

229. Kristina Cruickshank, a Houston resident, was 12 weeks pregnant with her first child when abdominal pain and heavy bleeding sent her to the emergency room. Kristina was told that her fetus had a cystic hygroma of unknown cause so large that her fetus was unlikely to survive. Yet because of S.B. 8, all her obstetrician was willing to offer her was weekly check-in appointments. Over the next three weeks, Kristina's condition dramatically deteriorated: she was in so much abdominal pain she could not walk; she had severe nausea and vomiting; she lost 15 pounds; she developed hyperthyroidism and was put on multiple thyroid medications. It was not until another emergency room visit at 15 weeks that she finally received a diagnosis: she had a partial molar pregnancy, a rare condition in which the fetus is not viable but that can cause the pregnant person to develop cancer. The condition had also led to massive cysts on her ovaries,

explaining her pain. Yet because her fetus had cardiac activity, multiple ethics committees refused to provide her abortion care. Kristina lay in agony for three days until her obstetrician finally found a hospital that would accept her case and a doctor who would perform a D&E. Kristina continues to battle the physical and emotional impact of her pregnancy, including rapid heart rate, shortness of breath, anxiety, and concerns for developing cancer.[57]

230. Elizabeth Weller, a Houston area resident, was 18 weeks pregnant when her water broke. In the emergency room, Elizabeth was diagnosed with PPROM, and after speaking with her obstetrician about the medical risk and the likelihood that her baby would not survive, she decided she wanted to terminate the pregnancy. Despite her obstetrician's pleading, however, the hospital said they were unable to offer her abortion unless she got "sick." For nearly a week, Elizabeth had many symptoms—cramps, bleeding, passing clots of blood, irregular discharge, vomiting—but was repeatedly told that her symptoms were not severe *enough*. Finally, when the discharge from her body became dark and foul smelling, the hospital at last agreed to provide an abortion. Her daughter was stillborn.[58]

231. Kailee DeSpain, a resident of Cleburne, was 19 weeks pregnant when she learned her baby had triploidy, or an extra set of chromosomes, leading to heart, lung, brain, and kidney anomalies that made it highly unlikely he would survive to birth. Kailee had already had two miscarriages, a stillborn, and uterine cancer, and was desperately hoping this pregnancy would "stick." She was counseled that continuing the pregnancy would put her at high risk of multiple

[57] Julian Gill, *Texas' Abortion Laws Led to 3-Day Delay for Houston Woman's Pregnancy Loss Treatment, Doctor Says*, Houston Chronicle (Sept. 7, 2022), https://www.houstonchronicle.com/news/houston-texas/health/article/Waiting-in-vain-Texas-abortion-laws-stymie-17424262.php.

[58] Carrie Feibel, *Because of Texas' Abortion Law, Her Wanted Pregnancy Became a Medical Nightmare*, NPR (July 26, 2022), https://www.npr.org/sections/health-shots/2022/07/26/1111280165/because-of-texas-abortion-law-her-wanted-pregnancy-became-a-medical-nightmare; Susan Rinkunas, *After Nightmare Pregnancy Loss Under an Abortion Ban, Texas Woman Weighs Trying Again,* Jezebel (Jan. 24, 2023), https://jezebel.com/texas-woman-pregnancy-loss-discharge-1850020829.

complications including blood clots, preeclampsia, placental abnormalities, and cancer, but that her only option for abortion care was to leave the state. Kailee was docked pay at work because she had already taken too many sick days, and she and her husband struggled to find the money to travel and pay for an abortion in New Mexico. Kailee's obstetrician has now advised her not to get pregnant again, not in Texas.[59]

232. A League City resident was 15 weeks pregnant with her first child when she learned her baby had fetal hydrops condition, Turner Syndrome, and other genetic conditions, and likely would not survive to birth. The woman was suffering from severe swelling, high blood pressure, severely elevated liver enzymes, and her doctors worried that she was also developing Mirror syndrome, a life-threatening condition involving severe hypertension and swelling. Yet she was told that anything short of liver failure or a stroke would not be enough to warrant an abortion procedure.[60]

233. Other accounts of anonymous pregnant people in Texas denied care include: a woman with a twin pregnancy delivered one stillborn at 15 weeks and continued pregnancy of the remaining baby put her at high risk of infection, but she was denied an abortion and returned two weeks later with sepsis and an acute kidney injury; a woman at a small rural hospital was 17 weeks pregnant when her water broke, and after being denied care, she was forced to travel to New Mexico for abortion care;[61] a woman whose cancer was in remission before pregnancy saw it come

[59] Elizabeth Cohen & Danielle Herman, *Why a Woman's Doctor Warned Her Not to Get Pregnant in Texas*, CNN (Sept. 10, 2022), https://www.cnn.com/2022/09/09/health/abortion-restrictions-texas/index.html; Brian Scott, *'What About Women Like Me?': North Texas Couple's Post About Pregnancy Struggle, Abortion Goes Viral*, Spectrum News 1 (May 19, 2022), https://spectrumlocalnews.com/tx/south-texas-el-paso/news/2022/05/18/tx-couple-shares-tough-time-under-new-abortion-law.

[60] Courtney Carpenter, *League City Family in 'Nightmare' Situation Under Texas Abortion Law*, ABC13 (Sept. 29, 2022), https://abc13.com/texas-abortion-laws-heartbeat-act-senate-bill-8-pregnant-woman/12277047.

[61] J. David Goodman & Azeen Ghorayshi, *Women Face Risks as Doctors Struggle with Medical Exceptions on Abortion*, N.Y. Times (July 20, 2022), https://www.nytimes.com/2022/07/20/us/abortion-save-mothers-life.html.

back aggressively after she got pregnant with her second child, and she was forced to travel out of state for the abortion that would allow her to resume cancer treatments;[62] a woman in San Antonio started to miscarry and was denied care until the fetus's heartbeat stopped, but in the meantime, the woman developed a dangerous womb infection, lost multiple liters of blood, and was put on a breathing machine.[63]

234. These stories are not unique to Texas. Since *Roe v. Wade* was overturned last year, multiple state abortion bans have gone into effect, and pregnant people in these states with emergent health conditions are facing similar barriers to care:

235. Madison Underwood, a Tennessee resident, was nearly 17 weeks pregnant when, during a routine ultrasound, she was informed that her fetus had not formed a skull. She was advised that continuing the pregnancy could lead to sepsis, critical illness, or even death. Madison postponed her wedding to schedule her abortion. But while undergoing a pre-abortion ultrasound, Madison was informed that her procedure had been cancelled because it had been determined that the legal risks in Tennessee were too high. Madison remembered wondering: "They're just going to let me die?" Madison was forced to travel hundreds of miles to receive care in Georgia, where, at the time, abortion was legal until 20 weeks.[64] Presently a 6-week ban is in effect in Georgia.

236. Allie Phillips, a Tennessee resident, was 19 weeks pregnant when her baby was diagnosed with holoprosencephaly, a congenital defect where the brain does not develop properly,

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[62] Laura Ungar & Heather Hollingsworth, *Despite Dangerous Pregnancy Complications, Abortions Denied*, AP News (Nov. 20, 2022), https://apnews.com/article/abortion-science-health-business-890e813d855b57cf8e92ff799580e7e8.

[63] Lindsey Tanner, *Abortion Laws Spark Profound Changes in Other Medical Care*, AP News (July 16, 2022), https://apnews.com/article/abortion-science-health-medication-lupus-e4042947e4cc0c45e38837d394199033.

[64] Neelam Bohra, *'They're Just Going to Let Me Die?' One Woman's Abortion Odyssey*, N.Y. Times (Aug. 1, 2022), https://www.nytimes.com/2022/08/01/us/abortion-journey-crossing-states.html?referringSource=articleShare.

and other structural abnormalities. Allie was told that her baby would not survive to birth, and that the problems would only get worse the longer she continued her pregnancy. Her doctor said that due to Tennessee's law, she could not offer Allie advice on abortion, and if it was something Allie wanted to do, she would have to do her own research. To make things worse, Allie and her husband had to explain the situation to their 5-year-old daughter. Allie has been documenting her journey on Tik Tok and is planning to travel to New York for an abortion.[65]

237. "Sarah," a Tennessee resident, went to the emergency room with severe abdominal pain. Even though she had an IUD, tests revealed that she had an ectopic pregnancy—a relatively common occurrence when an IUD fails—and was bleeding internally. Instead of receiving the immediate treatment she needed, however, Sarah was forced to endure hours of pain and severe bleeding while hospital attorneys attempted to determine whether providing her with abortion care would be prohibited under the state's ban. Almost ten hours later, after drafting twenty paragraphs of rationale for why an abortion was necessary, the hospital finally performed an abortion and were forced to remove part of one of her fallopian tubes to save her life.[66]

238. Kaitlyn Joshua, a Louisiana resident, was nearly 11 weeks pregnant when she started bleeding heavily, passing clots and tissue, and experiencing pain that she described as being worse than childbirth. Kaitlyn learned that her fetus had stopped growing past seven or eight weeks and that it only had faint cardiac activity, but despite two emergency room visits at two different

[65] Michael Daly, *Tennessee Abortion Ban a 'Nightmare' for Woman With Doomed Pregnancy*, Daily Beast (Feb. 28, 2023), https://www.thedailybeast.com/tennessee-abortion-ban-a-living-nightmare-for-woman-with-doomed-pregnancy.

[66] Steve Cavendish, *Sarah Needed an Abortion. Her Doctors Needed Lawyers*, Nashville Scene (Dec. 20, 2022), https://www.nashvillescene.com/news/citylimits/sarah-needed-an-abortion-her-doctors-needed-lawyers/article_472a621e-7fdb-11ed-bf8d-0797b6012be2.html. Unlike Texas, Tennessee's abortion bans do not explicitly exclude ectopic pregnancy or miscarriage care from the definition of "abortion."

hospitals, she was repeatedly denied a D&C due to fear regarding Louisiana's abortion bans. After this experience, she and her husband have decided not to have any more children for now.[67]

239. Nancy Davis, a Louisiana resident, was around 10 weeks pregnant when an ultrasound revealed that her fetus had acrania, a condition where the fetus is missing part of its skull. Nancy was counseled that her fetus would die shortly after birth but was refused abortion care because hospital officials were unsure whether the exceptions to Louisiana's abortion-bans applied to her case. Nancy was eventually forced to make an arduous, 1,400-mile journey to New York to receive the care she needed.[68]

240. Christina Zielke was visiting Ohio when she started bleeding. A few weeks earlier, doctors in Washington D.C. told her that she was likely miscarrying because her fetus had no cardiac activity, so when she started bleeding, she assumed that she was simply passing the pregnancy. The next day, however, she started bleeding profusely and passing large clots. In the emergency room, an ultrasound confirmed that the fetus had no cardiac activity, and even though she was informed that an abortion is often required to stop such bleeding, she was not offered an abortion procedure. Instead, she was discharged with blood running down her shoes.[69]

241. Tara George, an Ohio resident, was 20 weeks pregnant with her first child when she learned that her baby had multiple conditions in its bladder, heart, and kidneys, and likely

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[67] Rosemary Westwood, *Bleeding and in Pain, She Couldn't Get 2 Louisiana ERs to Answer: Is It a Miscarriage?,* NPR (Dec. 29, 2022), https://www.npr.org/sections/health-shots/2022/12/29/1143823727/bleeding-and-in-pain-she-couldnt-get-2-louisiana-ers-to-answer-is-it-a-miscarria. There are multiple overlapping and inconsistent abortion bans currently in effect in Louisiana, contributing to the confusion regarding the scope of the state's abortion exceptions. *See June Med. Servs., LLC v. Landry,* No. C-720988, 2022 WL 2824316 (La. Dist. Ct. July 7, 2022).

[68] Ramon Antonio Vargas, *Louisiana Woman Carrying Unviable Fetus Forced to Travel to New York for Abortion*, The Guardian (Sept. 14, 2022), https://www.theguardian.com/us-news/2022/sep/14/louisiana-woman-skull-less-fetus-new-york-abortion.

[69] Selena Simmons-Duffin, *Her Miscarriage Left Her Bleeding Profusely. An Ohio ER Sent Her Home to Wait,* NPR (Nov. 15, 2022), https://www.npr.org/sections/health-shots/2022/11/15/1135882310/miscarriage-hemorrhage-abortion-law-ohio.

would not survive to birth. She was advised that continuing her pregnancy put her at a higher risk of developing preeclampsia, placental abruption, and deadly blood clots. Yet, she was denied an abortion because the hospital said it was unsure whether her conditions satisfied Ohio's abortion-ban exceptions. She and her husband immediately scheduled an abortion at a hospital in Michigan. But, soon after, a Michigan appeals court allowed the state's 1931 abortion ban to go into effect and, as a result, Tara was denied abortion care for the second time in under a week. After struggling to find care in other states, she received a call from a doctor in Michigan who told her that they could go ahead with the procedure as a judge had issued a temporary restraining order, blocking the ban's enforcement. That same day, she rushed to Michigan where she was finally able to receive the care she needed.[70]

242. Beth Long, an Ohio resident, was around 17 weeks pregnant when she learned her baby had limb body wall complex, a rare condition where the baby's organs develop outside its body. Beth, who had undergone extensive and expensive fertility treatment to get pregnant, was told that the condition posed health risks for her too, including dangerous bleeding that could necessitate a hysterectomy. Beth was advised to terminate the pregnancy as soon as possible. But because her life was not "imminently in danger," her state-issued insurance would not cover the $20,000-$30,000 procedure in Ohio, and Beth was forced to delay abortion care for weeks and ultimately travel to an out of state hospital that would do the procedure for a discounted rate. Beth called it "the most dehumanizing experience of my life."[71]

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[70] Abigail Abrams, *'Never-Ending Nightmare.' An Ohio Woman Was Forced to Travel Out of State for an Abortion*, Time (Aug. 29, 2022), https://time.com/6208860/ohio-woman-forced-travel-abortion.

[71] Elizabeth Cohen & Amanda Musa, *Ohio Abortion Law Meant Weeks of "Anguish," "Agony" for Couple Whose Unborn Child Had Organs Outside Her Body*, CNN (Feb. 8, 2023), https://www.cnn.com/2023/02/08/health/ohio-abortion-long/index.html.

243. Carmen Broesder, an Idaho resident, was 6 weeks pregnant when she began experiencing heavy bleeding and intense pain and cramps. Despite multiple trips to emergency rooms at different hospitals, Carmen was repeatedly denied abortion care, with her physicians citing trepidation regarding Idaho's abortion ban. Carmen documented her 19-day miscarriage on social media.[72]

244. Alyssa Gonzales, an Alabama resident, was heartbroken when her second baby was diagnosed with trisomy 18. Yet in her words, "the worst was yet to come," as Alabama's trigger law had taken effect weeks earlier and Alyssa was told she did not qualify for an exception. Alyssa did not have the money to travel for an abortion, but after connecting with an abortion fund who offered financial support, Alyssa loaded her infant son, her fiancé, and his parents in the car, and they drove 11 hours to an abortion provider in Washington, D.C.[73]

245. Jill Hartle, a resident of South Carolina, was 22 weeks pregnant when her fetus was diagnosed with hypoplastic left heart syndrome, a condition where the fetal heart does not properly develop. But Jill was told there was nothing doctors could do for her at home because *Roe v. Wade* had been overturned weeks earlier and South Carolina's 6-week abortion ban was in effect. Jill was ultimately able to get an appointment for an abortion in Washington, D.C. but had to wait two weeks for an appointment due to the influx of patients.[74]

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[72] Mary Kekatos, *Idaho Woman Shares 19-Day Miscarriage on TikTok, Says State's Abortion Laws Prevented Her from Getting Care*, ABC News (Jan. 21, 2023), https://abcnews.go.com/Health/idaho-woman-shares-19-day-miscarriage-tiktok-states/story?id=96363578.

[73] Alyssa Gonzales, *I Live in Alabama. Our Cruel New Abortion Law Has Made My Life Absolute Hell*, Huffpost Personal (Oct. 21, 2022), https://www.huffpost.com/entry/supreme-court-roe-v-wade-alabama_n_63486af5e4b0b7f89f546712.

[74] Andrea Michelson, *Former Ms. South Carolina Says She Was Forced to Carry Her Fetus Until 25 Weeks—2 Months After Doctors Detected a Deadly Heart Defect*, Insider (Nov. 14, 2022), https://www.insider.com/former-pageant-winner-describes-abortion-at-25-weeks-post-roe-2022-11.

246. Mylissa Farmer, a Missouri resident, was nearly 18 weeks pregnant when her water broke. Her doctor diagnosed her with PPROM and advised her to terminate the pregnancy to protect her health. Due to Missouri's abortion ban, however, she was advised that doctors could only intervene if her vitals plummeted, infection set in, or the fetus's cardiac activity stopped. Mylissa worried that by the time there was an emergency, it would be too late for her, as she was already at higher risk of maternal thrombosis, infection, and severe blood loss. After struggling to find an abortion provider in three other states, she eventually found a clinic in Illinois and traveled hundreds of miles to receive the care she needed.[75] Upon information and belief, Mylissa is the first patient since *Roe* was overturned to submit an EMTALA complaint based on being denied an abortion for an emergent medical condition.[76]

247. "R," a Missouri resident, found out she was pregnant a week after *Roe v. Wade* was overturned. R had previously been diagnosed with a "bicornate uterus," a congenital abnormality that creates significant risks for carrying a child to term. R immediately knew that she wanted an abortion. Missouri's trigger ban had just taken effect, so R started calling clinics out of state, but they were all booked up. It took seven weeks before she was able to get an appointment in Illinois.[77]

248. Deborah Dorbert, a Florida resident, was 24 weeks pregnant when her fetus was diagnosed with Potter Syndrome, a condition where the kidneys do not develop properly and do not produce a sufficient amount of amniotic fluid. Deborah was told that condition is incompatible with life as babies born with Potter Syndrome are both unable to breathe and go into renal failure

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[75] Susan Szuch, *After Missouri Banned Abortions, She Was Left 'With a Baby Dying Inside.' Doctors Said They Could Do Nothing*, Springfield News-Leader (Oct. 19, 2022), https://www.news-leader.com/story/news/local/ozarks/2022/10/19/missouri-laws-abortion-ban-left-her-with-a-baby-dying-inside-pprom/10366865002.

[76] *Admin. Compl. (Mylissa Farmer)*, U.S. Dep't of Health & Human Servs. (Nov. 8, 2022), https://nwlc.org/wp-content/uploads/2022/11/2022.11.08-Mylissa-Farmer-EMTALA-complaint.pdf.

[77] Carter Sherman, *She Feared Giving Birth Would Kill Her. She Fled Her State for an Abortion.*, Vice (Oct. 26, 2022), https://www.vice.com/en/article/m7gx4v/abortion-missouri.

at birth, and that the risks to Deborah will increase as her pregnancy continues. Deborah and her husband decided that they wanted an abortion as soon as possible due to concern for Deborah's physical and mental health, worries about the baby suffering, and their desire to begin the grieving process. But because no one in Florida will perform the abortion under their medical exception, and they worry about the financial and logistical challenges of leaving the state for care, Deborah is still pregnant. Florida has a 15-week abortion ban that has been effect since shortly after Roe was overturned—it has been challenged but is in effect while appeals continue.[78]

249. Anabely Lopes, a Florida resident, was 15 weeks pregnant when her fetus was diagnosed with trisomy 18. Florida's 15-week ban had gone into effect just days earlier, and Anabely was forced to travel to Washington, D.C. for an abortion. The experience was so painful and devastating that Anabely had thoughts of suicide.[79]

250. Amy English, a Kentucky resident, was 20 weeks pregnant when she learned her baby had acrania and anencephaly and would not survive to birth. Amy wanted an abortion but erupted into sobs when her doctor told her that it was illegal in Kentucky and she should call hospitals in Illinois. Amy remembers thinking, "Am I just supposed to Google the number, call the front desk and ask, 'How do I get an abortion at your hospital?'" Amy, her husband, and her sister-in-law called multiple clinics, but due to abortion laws in Indiana and Ohio, she had trouble

[78] Frances Stead Sellers, *Her Baby Has a Deadly Diagnosis. Her Florida Doctors Refused an Abortion*, Washington Post (Feb. 18, 2023), https://www.washingtonpost.com/health/2023/02/18/florida-abortion-ban-unviable-pregnancy-potter-syndrome; Maya Yang, *Florida Couple Unable to Get Abortion Will See Baby Die After Delivery*, The Guardian (Feb. 18, 2023), https://www.theguardian.com/world/2023/feb/18/florida-abortion-law-couple-birth.

[79] Timothy Bella, *Fla. Woman Forced to Fly to D.C. for Abortion Returns for State of the Union*, Washington Post (Feb. 7, 2023), https://www.washingtonpost.com/politics/2023/02/07/state-of-union-abortion-florida-anabely-lopes.

finding a provider who could do a D&E. Eventually, she found a hospital in 400 miles away in Illinois that agreed to give her an induction abortion.[80]

251. Leah Martin, a Kentucky resident, was 12 weeks pregnant when she learned her fetus had triploidy and she was diagnosed with a partial molar pregnancy. She was told that her pregnancy could give her cancer if she did not get an abortion. But Kentucky's abortion bans had taken effect two weeks earlier and the hospital told Leah that they could not perform the abortion while litigation of the abortion bans continued. But Leah got lucky. Shortly after her diagnosis, a Kentucky judge temporarily enjoined the abortion bans and Leah got an appointment at Kentucky's sole abortion clinic. The injunction was lifted just days after her procedure and the abortion bans remain in effect today.[81]

252. Additional stories of pregnant people not publicly named have appeared constantly in the news since *Roe v. Wade* was overturned. For example: a Texas woman whose fetus was diagnosed with acrania spent six weeks putting together the resources to travel out of state for an abortion, and she ended up needing a hysterectomy that likely would not have been necessary if she had been able to get an abortion sooner;[82] a Tennessee woman whose fetus was diagnosed with a genetic condition putting her at risk of preeclampsia was forced to take a 6-hour ambulance ride to North Carolina where, on arrival, her blood pressure was dangerously high and she was showing signs of kidney failure;[83] a Tennessee woman was diagnosed with a cesarian scar ectopic

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[80] Alex Acquisto, *A 'Twisted' Experience: How KY's Abortion Bans Are Depriving Pregnant Patients of Health Care*, Lexington Herald Leader (Feb. 22, 2023), https://www.kentucky.com/news/politics-government/article271925592.html.

[81] *Id.*

[82] Selena Simmons-Duffin, *3 Abortion Bans in Texas Leave Doctors 'Talking in Code' to Pregnant Patients*, NPR (March 1, 2023), https://www.npr.org/sections/health-shots/2023/03/01/1158364163/3-abortion-bans-in-texas-leave-doctors-talking-in-code-to-pregnant-patients.

[83] Susan Rinkunas, *A Tennessee Woman Had to Take a 6-Hour Ambulance Ride to Get an Abortion*, Jezebel (Oct. 17, 2022), https://jezebel.com/a-tennessee-woman-had-to-take-a-6-hour-ambulance-ride-t-1849668907.

pregnancy and traveled to Georgia which, though it has its own abortion ban, at least has an explicit exception for ectopic pregnancies, unlike Tennessee;[84] a Florida woman pregnant with twins was 20 weeks pregnant when her water broke and she partially delivered one of the fetuses, but she was forced to wait a week until both fetuses' hearts stopped to receive medical care;[85] people whose fetuses were diagnosed with fatal conditions like anencephaly, some of whom were able to travel out of state for abortion care, while others were forced to carry the pregnancies to term and suffer through the emotional trauma of a stillbirth;[86] and people who have been denied or delayed in receiving treatment for ectopic pregnancies or miscarriage despite intense pain and bleeding.[87]

B. Confusion and Fear Throughout the Medical Community Regarding Texas's Abortion Bans and Similar Bans Around the Country

253. The stories of pregnant people described above reflect the widespread confusion among the medical community regarding the proper application of the Emergent Medical Condition Exception, combined with fear that a physician's good faith reliance on the exception could nonetheless result in disciplinary sanctions, civil penalties, and/or a lengthy prison sentence.

254. After S.B. 8 took effect, researchers from Texas Policy Evaluation Project, the University of Texas at Austin, Baylor College of Medicine, and the Pegasus Health Justice Center

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[84] Poppy Noor, *'I Cried With Her': The Diary of a Doctor Navigating a Total Abortion Ban*, The Guardian (Feb. 22, 2023), https://www.theguardian.com/world/2023/feb/22/diary-doctor-navigating-total-abortion-ban-tennessee.

[85] Rachel Rapkin, *Here's the Harrowing Story of One of My Patients After Florida's 15-Week Abortion Ban*, Tampa Bay Times (Jan. 21, 2023), https://www.tampabay.com/opinion/2023/01/21/heres-harrowing-story-one-my-patients-after-floridas-15-week-abortion-ban-column.

[86] Nilo Tabrizy et al., *"Do No Harm": OB-GYNs Weigh the Legal Impact of Abortion Bans*, N.Y. Times (Sept. 10, 2022), https://www.nytimes.com/video/us/100000008489880/abortion-bans-maternal-health.html?searchResultPosition=14; Noor, *supra* n.84.

[87] *Confusion Post-Roe Spurs Delays, Denials for Some Lifesaving Pregnancy Care*, Washington Post (July 16, 2022), https://www.washingtonpost.com/health/2022/07/16/abortion-miscarriage-ectopic-pregnancy-care; Stephanie Wenger, *Tennessee Doctor Details Patient's Experience Being Unable to Get Pills to Complete Her Miscarriage*, People (July 8, 2022), https://people.com/health/tenn-doctor-details-patients-experience-being-unable-to-get-pills-to-complete-her-miscarriage.

interviewed 25 clinicians in general obstetrics and gynecology, maternal and fetal medicine, and genetic counseling regarding the impact S.B. 8 has had on their practice. The results of these interviews were published in the *New England Journal of Medicine*[88] and show that fear and confusion among the medical profession regarding abortion bans is widespread:

255. There is no consensus view among physicians on the meaning of the Emergent Medical Condition Exception, leading to significant chilling in the provision of pregnancy-related care that involves abortion.

256. Some physicians believe that "[p]eople have to be on death's door to qualify for maternal exemptions to SB8." Accordingly, some clinicians force patients with "pregnancy complications or preexisting medical conditions that may be exacerbated by pregnancy" to "delay an abortion until their conditions become life-threatening," *i.e.*, until the patient is in crisis, and thus "qualify as medical emergencies."[89] In other words, instead of being offered expectant management *or* termination of pregnancy when the emergent conditions present themselves, pregnant people are given one option: wait to miscarry without medical intervention or until the emergent conditions have made them so horribly ill that they are at risk of imminent death.

257. For example, "[s]ome clinicians believe that patients with rupture of membranes before fetal viability are eligible for a medical exemption under SB8, while others believe these patients cannot receive an abortion so long as there is fetal cardiac activity." Physicians who believe they cannot intervene before a patient falls sick with infection will send patients home,

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[88] Whitney Arey et al., *A Preview of the Dangerous Future of Abortion Bans – Texas Senate Bill 8*, 387 N. Engl. J. Med. 388, 388-89 (Aug. 4, 2022); *see also* Charlotte Huff, *In Texas, Abortion Laws Inhibit Care for Miscarriages*, NPR (May 10, 2022), https://www.npr.org/sections/health-shots/2022/05/10/1097734167/in-texas-abortion-laws-inhibit-care-for-miscarriages; María Méndez, *Texas Laws Say Treatments for Miscarriages, Ectopic Pregnancies Remain Legal But Leave Lots of Space for Confusion*, Tex. Tribune (July 20, 2022), https://www.texastribune.org/2022/07/20/texas-abortion-law-miscarriages-ectopic-pregnancies.

[89] Arey et al., *supra* n.88 at 389.

"only to see them return with signs of sepsis." Another patient received an abortion only after her "severe cardiac condition" caused her to be admitted to the intensive care unit.[90]

258. All of the hospitals where the interviewees practice prohibited fetal reduction, "even though in some cases (e.g., complications of monochorionic twins) failure to perform the procedure could result in the loss of both twins."[91] This reflects Lauren M. and Ashley's personal experiences.

259. Some of the interviewed clinicians reported that, based on legal guidance, they do not believe they can even counsel patients regarding "the availability of abortion in cases of increased maternal risks or poor fetal prognosis, although before SB8 they would have done so."[92] Again, this reflects the experiences of Amanda, Lauren M., Lauren H., Anna, and Ashley, who sensed that their medical providers felt muzzled.

260. Fear of liability under the abortion bans is so great that some physicians have even changed their standard treatment methods from D&E to induction or hysterotomy (a procedure similar to Caesarean section).[93]

261. The confusion extends to physicians who do not perform abortions but are involved in advising on the appropriate treatment or in providing sedation, such as anesthesiologists who place epidurals during labor inductions. These physicians reportedly worry about potential liability for "aiding and abetting" an illegal abortion and thus decline to participate.[94]

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[90] *Id.*

[91] *Id.*

[92] *Id.* at 388.

[93] *Id.* at 390.

[94] *Id.* at 389-90.

262. Confusion over the Emergent Medical Condition Exception extends to ectopic pregnancies as well. At least one Texas hospital no longer treats patients with ectopic pregnancies implanted in cesarean scars, even though ectopic pregnancies are excluded from Texas's definition of abortion and leading experts at the Society for Maternal-Fetal Medicine recommend treating these "life-threatening pregnancies" with "surgical or medical" termination.[95]

263. Because of the law's severe restrictions on maternal health and wellbeing, some doctors have departed Texas for states without equally strict abortion bans. The result is fewer doctors who are fully equipped to treat patients suffering from serious pregnancy complications and challenges with training the next generation of doctors.[96]

264. Another study was conducted at two large hospitals in Dallas County, Parkland Hospital and the William P. Clements Jr. University Hospital after S.B. 8 took effect. The study documented a significant increase in maternal morbidity among patients with preterm labor who would have been promptly offered induction abortions before the law but, due to fear regarding S.B. 8, were not offered such treatment until there physicians determined that an emergent condition posed "an immediate threat to maternal life." The study followed 28 patients (26 with PPROM, 2 with pregnancy tissue prolapsed into the vagina). Among these patients, 43% (12 of 28) experienced infection or hemorrhage and one patient required a hysterectomy. Other maternal morbidities included intensive care unit admissions, blood transfusions, postpartum emergency room visits, and postpartum readmission.[97]

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[95] *Id.* at 389 (citing Russell Miller et al., *Society for Maternal-Fetal Medicine (SMFM) Consult Series #49: Cesarean Scar Pregnancy*, 222 Am. J. Obstetrics & Gynecology B2-B14 (May 2020); *see also* Patricia Santiago-Munoz, M.D., *Cesarean Scar Ectopic Pregnancy: Facts and Treatment Options*, U.T. Sw. Med. Ctr. (Aug. 23, 2022), https://utswmed.org/medblog/cesarean-scar-ectopic-pregnancy (explaining that a CSEP "may result in hemorrhage" and "potentially lead[] to a hysterectomy, damage to surrounding organs, or death of the pregnant patient").

[96] Arey et al., *supra* n.88 at 390.

[97] Anjali Nambiar, et al., *Maternal Morbidity and Fetal Outcomes Among Pregnant Women at 22 Weeks'*

265. The Dallas hospitals study concluded that "state-mandated expectant management" is associated with "significant maternal morbidity."[98]

266. State-mandated expectant management under Texas's abortion bans resulted in a lapse of nine days on average between first diagnosis and the development of "complications that qualified as an immediate threat to maternal life."[99]

267. The Dallas hospitals study examined practices prior to the overturning of *Roe* and the triggering of Texas's complete ban on abortion. It also examined practices at level IV designated maternal care facilities in large urban centers. On information and belief, delays and maternal morbidities are worse for patients who first present to non-level IV designated maternal care facilities, for patients who live far from large urban centers, and for patients after the Trigger Ban sprung into effect.

268. An additional study focused on patients with lethal or life-limiting fetal diagnoses in Texas after S.B. 8 took effect. The study documented self-censoring among health care providers regarding abortion because of a fear of potential liability under S.B. 8, and a resulting lack of information for patients about their pregnancy options, including abortion. The study followed 16 patients who received lethal or life-limiting fetal diagnoses in Texas after S.B. 8 took effect and ultimately pursued an abortion out-of-state. Patients reported feeling isolated after receiving their diagnoses as their health care providers were unable to speak openly with them about their options, including abortion. Instead, the study documented that patients were forced to rely on Google and their own knowledge about abortion, all the while stating that they would have

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Gestation or Less with Complications in Two Texas Hospitals After Legislation on Abortion, 227 Am. J. Obstetrics & Gynecology 648 (2022), https://doi.org/10.1016/j.ajog.2022.06.060.

[98] *Id.*

[99] *Id.*

preferred to receive information straight from their Texas doctor. The study concluded that restrictions like S.B. 8 "erode the patient–physician relationship, evoke fear and safety concerns, and create a significant burden on patients to understand pregnancy options and navigate the process of abortion alone."[100]

269. The patients study concluded that restrictions like S.B. 8 "erode the patient–physician relationship, evoke fear and safety concerns, and create a significant burden on patients to understand pregnancy options and navigate the process of abortion alone."

270. In the months since *Roe v. Wade* was overturned and other state bans have taken effect, confusion over the scope of exceptions to abortion bans has extended beyond Texas. For example, another article in *the New England Journal of Medicine* explained that physicians and other medical professionals nationwide have struggled to translate legislative exceptions to abortion bans into actionable clinical guidelines, with disastrous impacts on patient care. Without further explanation, physicians do not know if, for example, "a patient with pulmonary hypertension, for whom we cite a 30-to-50% chance of dying with ongoing pregnancy," is sufficiently at risk of death or substantial impairment of a major bodily function to permit abortion.[101]

271. Other studies of the impact on the medical profession of reversing *Roe v. Wade* are ongoing, including a study out of the University of California San Francisco designed to examine

[100] Courtney C. Baker et al., *Texas Senate Bill 8 and Abortion Experiences in Patients with Fetal Diagnoses*, 141 Obstetrics & Gynecology 602 (2023), https://pubmed.ncbi.nlm.nih.gov/36735418.

[101] Lisa H. Harris, *Navigating Loss of Abortion Services—A Large Academic Medical Center Prepares for the Overturn of* Roe v. Wade, 386 N. Engl. J. Med. 2061, 2061 (June 2, 2022) (describing a Michigan hospital's efforts to interpret a state law permitting abortions to "preserve the life" of the pregnant person).

how making abortion illegal is forcing clinical care for pregnant patients to deviate from the usual standard of care.[102]

272. In legal challenges to state abortion bans since *Roe* was overturned, medical professionals around the country have testified about the challenges of complying with state abortion bans, telling harrowing stories about their patients. These include: a sixteen-year-old girl who had such debilitating hyperemesis that she lost over 20 pounds and was forced to travel out of state *twice* to receive the care she needed after being denied an abortion; a patient with Stage III Melanoma who could not receive treatment until her pregnancy was terminated but was told she would have to travel out of state to receive an abortion, causing her to break down and cry inconsolably; and multiple patients diagnosed with PPROM but denied abortion care.[103] In one case, a PPROM patient was forced to endure an excruciating, hours-long delivery of a nonviable fetus that eventually caused her to hemorrhage.[104] Physicians have also testified about patients with mental health conditions that necessitated abortion care, including attempted suicide.[105]

273. These physicians have also testified about patients they treated before *Roe* was overturned who they may not be able to help under the new state abortion bans if the same patient presented for care today. For example: patients whose fetuses were diagnosed with triploidy, causing some to develop HELLP syndrome and others preeclampsia with severe features; a patient who developed disseminated intravascular coagulation ("DIC")—a condition that causes pregnant

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[102] *Dobbs Impact Study*, Univ. Cal. S.F., https://carepostroe.ucsf.edu.

[103] Aff. of Aeran Trick ¶¶ 6, 9, 11, *Preterm Cleveland v. Yost*, No. A2203203, 2022 WL 4279758 (Ohio Ct. Com. Pl. Sept. 2, 2022); Aff. of Valerie Williams, M.D. ¶¶ 10-11, *June Med. Servs., LLC v. Landry*, No. C-720988, 2022 WL 2902625 (La. Dist. Ct. July 13, 2022) (hereinafter "Williams Aff.").

[104] Williams Aff. ¶ 11.

[105] *See, e.g.*, Aff. of Dr. Sharon Liner ¶ 11, *Preterm Cleveland v. Yost*, No. A2203203 (Ohio Ct. Com. Pl. Sept. 2, 2022) ("We have had at least 3 patients threaten to commit suicide. Another patient stated that she would attempt to terminate her pregnancy by drinking bleach."); Aff. of David Burkons, M.D. ¶ 9, *Preterm Cleveland v. Yost*, No. A2203203, 2022 WL 4279758 (Ohio Ct. Com. Pl. Sept. 2, 2022).

patients to lose large volumes of blood—due to placental abruption; a patient with preeclampsia with severe features that caused fluid to accumulate between the tissues lining her lungs and chest; a patient with preeclampsia with severe features caused by a partial molar pregnancy; a patient who experienced a septic abortion; a patient who went into hypovolemic shock after experiencing uncontrollable vaginal bleeding at 19 weeks of pregnancy; a patient with bipolar disorder at risk of developing postpartum psychosis; and patients with panic disorders that lead to attempted suicide.[106]

274. Physicians have also provided compelling hypotheticals in their testimony that highlight the practical ramifications of unclear abortion-ban exceptions. For instance, one physician asked: "If a pregnant patient is experiencing renal failure, does she have to be on dialysis before a physician may perform an abortion that would otherwise be prohibited by the Ban? If a pregnant patient has a cardiac lesion, does a physician have to wait until she experiences heart failure to intervene? If a pregnant patient has a clogged blood vessel, does a physician have to wait until she experiences chest pain before terminating the pregnancy to prevent pulmonary embolism?" Aff. of Martina Badell, M.D. ¶ 30, *SisterSong Women of Color Reprod. Just. Collective v. Georgia*, No. 2022CV367796, 2022 WL 3335933 (Ga. Super. Ct. July 25, 2022).

[106] Decl. of Kylie Cooper, M.D. ¶¶ 6-12*, United States v. Idaho*, No. 1:22-cv-00329 (D. Idaho Aug. 8, 2022), ECF No. 17-7; Decl. of Dr. Emily Corrigan ¶¶ 20-30, *United States v. Idaho*, No. 1:22-cv-00329 (D. Idaho Aug. 8, 2022), ECF No. 17-6; Decl. of Stacy T. Seyb, M.D. ¶¶ 7-14, *United States v. Idaho*, No. 1:22-cv-00329 (D. Idaho Aug. 8, 2022), ECF No. 17-8; Aff. of Samantha Meltzer-Brody, M.D. ¶¶ 40-41, *SisterSong Women of Color Reprod. Just. Collective v. Georgia*, No. 2022CV367796, 2022 WL 3335938 (Ga. Super. Ct. July 23, 2022) ("I recall one patient who came to me with debilitating postpartum psychosis, a condition related to bipolar disorder that is often characterized by delusional thinking, typically focused on the infant. . . . The symptoms are excruciating . . . and there is a strong association between postpartum psychosis and maternal suicide. This patient was still in my treatment—no longer experiencing postpartum psychosis but still navigating her bipolar disorder—when she learned of an accidental pregnancy. She was gravely concerned about either stopping her medication during pregnancy and experiencing a worsening of her bipolar disorder, or continuing her medication and exposing the fetus to serious teratogenic risks. But even more than that, she was terrified at the thought of experiencing postpartum psychosis again and potentially hurting her child or herself. This patient told me repeatedly that she felt such overwhelming distress at the thought of continuing the pregnancy that she would rather die than go on.").

Another physician queried: "[I]f I and another physician judge that a woman's neurological condition is so complicated by pregnancy that she might lose entirely the ability to breathe, and I perform a procedure, could another physician look at the patient's chart after the fact and think that we overestimated the danger, or that we should have delayed the abortion to see whether the patient's condition deteriorated?" Decl. of Nikki Zite, M.D., M.P.H. ¶ 21, *Memphis Ctr. for Reprod. Health v. Slatery*, No. 3:20-cv-00501 (M.D. Tenn. June 22, 2020), ECF No. 8-3.

III. THE TEXAS CONSTITUTION PROTECTS PREGNANT PEOPLE WITH EMERGENT MEDICIAL CONDITIONS AND THEIR PHYSICIANS FROM STATE DEPRIVATION OF THEIR RIGHTS

A. Pregnant People Have Fundamental and Equal Rights Under the Texas Constitution

275. The Supreme Court may have stripped pregnant people of their federal constitutional right to abortion, *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022), but that does not mean that Plaintiffs are without Constitutional Rights.

276. The Texas Constitution guarantees its citizens certain fundamental rights, specifically: "[n]o citizen of this State shall be deprived of life, liberty, property, privileges, or immunities, or in any manner disfranchised, except by the due course of the law of the land." Tex. Const. art. I, § 19. People do not lose these rights simply because they are pregnant. Moreover, Texas law cannot demand that a pregnant person sacrifice their life, their fertility, or their health for any reason, let alone in service of "unborn life," particularly where a pregnancy will not or is unlikely to result in the birth of a living child with sustained life.

277. The Texas Constitution also prohibits Texas law from excluding pregnant people with certain kinds of emergent conditions—for example, pregnant people whose health risks are not imminently "life-threatening"—from receiving appropriate and/or life-saving medical care.

278. The Texas Constitution also guarantees "equal rights" under the law and prohibits the law from "den[ying] or abridg[ing rights] because of sex." Tex. Const. art. I, §§ 3, 3a. To deny

a "woman known to be pregnant" equal access to life-saving and health-preserving medical care, simply because she is pregnant, would violate this foundational premise of equality under Texas law.

279. To the extent Texas's abortion bans bar the provision of abortion to pregnant people to treat medical conditions that pose a risk to the pregnant person's life or a significant risk to their health, the Bans violate pregnant people's fundamental rights under § 19 and their rights to equality under the law under §§ 3, 3a.

280. Indeed, Texas's abortion bans fail any level of constitutional review when applied to such pregnant people. "If the Texas [pre-*Roe* ban] statute were to prohibit an abortion even where the mother's life is in jeopardy, I have little doubt that such a statute would lack a rational relation to a valid state objective under the test stated in *Williamson* . . . ." *Roe v. Wade*, 410 U.S. 113, 173 (1973) (Rehnquist, J., dissenting). Because the abortion bans force pregnant people with emergent medical conditions to surrender their lives, health, and/or fertility, they have no rational relationship to protecting life, health, or any other legitimate state interest.

B. Texas-Licensed Physicians Have Liberty and Property Rights to Provide Care to Pregnant People with Emergent Conditions

281. The Texas Constitution guarantees that "[n]o citizen of this State shall be deprived of life, liberty, property, privileges, or immunities, or in any manner disfranchised, except by the due course of the law of the land." Tex. Const. art. I, § 19. The threatened enforcement of the abortion bans against physicians who in good faith provide abortions for pregnant people suffering emergent medical conditions infringes this constitutional guarantee.

282. Section 19 guarantees Texas-licensed physicians the right to practice their profession by providing abortion to their pregnant patients to treat emergent medical conditions that the physician determines poses a risk to the patient's life or health.

283. To fulfill this guarantee, physicians must be able to exercise their good faith judgment in the care of their patients with emergent conditions without threat that the state will take their license and/or liberty if a prosecutor or jury second guesses their medical judgment.

284. Texas law authorizes Defendant TMB to institute disciplinary and licensing proceedings against any physician who performs an abortion that TMB determines did not meet the Emergent Medical Condition Exception. *See, e.g.*, Tex. Occ. Code §§ 165.001, 164.052(a)(5), 164.053(a), 164.055; Tex. Health & Safety Code § 170A.007. These proceedings may result in a provider losing their license to practice medicine. *See, e.g.*, Tex. Health & Safety Code § 170A.007.

285. Disciplinary actions are reported to the National Practitioner Data Bank[107] and can have collateral consequences on a physician's ability to practice in other U.S. states.[108] Defendant TMB, for example, requires physicians to make timely reports of any disciplinary actions taken by other jurisdictions against the physician, 22 Tex. Admin. Code § 173.3, and has taken disciplinary action against physicians based on conduct occurring in other states.[109] Upon information and belief, disciplinary sanctions may also result in loss of employment.

286. Physicians must make a substantial investment to obtain a medical license in Texas.

287. According to TMB, to be eligible for a physician's license in Texas, individuals must: graduate from an accredited medical school, having gained admission through a highly

[107] *See* 42 U.S.C. § 11132 (requiring state medical boards to report all revocations or suspensions of physician licenses); *see also* Nat'l Practitioner Data Bank, *Guidebook*, at Ch. E: Reports, Table E-1 (Oct. 2018), https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp (explaining state medical boards and hospitals have mandatory reporting obligations).

[108] *See, e.g.*, Tex. Admin. Code § 173.3(d) (requiring reporting within 30 days of any actions issued by another state); Tex. Med. Bd. Press Release at 4-5, *TMB Disciplines 27 Physicians at June Meeting, Adopts Rule Changes* (June 30, 2022), https://www.tmb.state.tx.us/dl/2B28AF92-02B2-0425-2295-86E2DEAD1C51 (describing "other states' [disciplinary] actions").

[109] Tex. Med. Bd. Press Release at 4-5, *TMB Disciplines 27 Physicians at June Meeting, Adopts Rule Changes* (June 30, 2022), https://www.tmb.state.tx.us/dl/2B28AF92-02B2-0425-2295-86E2DEAD1C51.

competitive application process which often necessitates incurring significant amounts of debt (in 2019, an average of between $94,399 and $142,797 for students at medical schools in Texas)[110]; complete at least one continuous year of graduate medical training or a fellowship; pass rigorous state examinations; practice medicine full-time for one year; and, *inter alia*, have no relevant disciplinary or criminal history. 22 Tex. Admin Code § 163.2.

288. If physicians meet these requirements and incur the substantial associated costs, they are eligible for full licensure in Texas for which they must apply. 22 Tex. Admin Code §§ 163.2, 163.4. Once granted, a physician may practice medicine within Texas and has a vested property interest in their license.

289. Revoking or suspending a physician's license based on a flawed interpretation of the Emergent Medical Condition Exception is improper interference with the physician's vested property interest in their license.

290. Further, sending a physician to prison for up to 99 years for providing timely and appropriate medical care to a pregnant person with an emergent medical condition is improper interference with the physician's liberty.

291. Physicians have constitutional rights under § 19 of the Texas Constitution including rights to liberty, property, and substantive due course of law. Even for laws that only touch on economic rights, § 19 requires a rational relationship to the purpose of the law.

292. As applied to pregnant people with emergent medical conditions and the physicians treating them, Texas's abortion bans fail to comply with the Texas Constitution. They do not serve a proper legislative purpose because far from furthering life, they harm pregnant people's lives,

[110] *See, e.g.*, *Medical School Debt Keeps Climbing,* Tex. Med. Ass'n (April 2020), https://app.texmed.org/tma.archive.search/files/53049/april_20_tm_educationinfographic.pdf.

and the lives of their children, without furthering potential life at all. Texas law also demands that there be a real and substantial connection between a legislative purpose and the language of the law as it functions in practice. For pregnant people with emergent medical conditions, there is none. Further, for patients with emergent conditions, Texas's abortion bans work an excessive burden on Physicians treating such patients relative to their purported purpose. *See, e.g.*, *Patel v. Tex. Dep't of Licensing & Reg.*, 469 S.W.3d 69, 80-81 (Tex. 2015).

CLAIMS

CLAIM I: DECLARATORY JUDGMENT

293. The allegations in paragraphs 1 through 292 above are incorporated as if fully set forth herein.

294. Plaintiffs hereby petition the Court pursuant to the UDJA.

295. Section 37.002 of the UDJA provides that it is remedial and its purpose is to settle and to afford relief from uncertainty and insecurity with respect to rights, status, and other legal relations; and it is to be liberally construed and administered.

296. Under Section 37.003 of the UDJA, a court of proper jurisdiction has the power to declare rights, status, and other legal relations, whether or not further relief is or could be claimed. The declaration may be either affirmative or negative in form and effect and the declaration has the force and effect of a final judgment or decree.

297. Plaintiffs thus seek a declaratory judgment that the exception to Texas's abortion bans, codified at Tex. Health & Safety Code §§ 170A.001-002, 171.002(3), 171.203-205, permits physicians to provide a pregnant person with abortion care when the physician determines, in their good faith judgment and in consultation with the pregnant person, that the pregnant person has a physical emergent medical condition that poses a risk of death or a risk to their health (including their fertility).

298. Plaintiffs also seek a declaratory judgment that, at a minimum, Texas's abortion bans do not preclude a physician from providing abortion care where, in the physician's good faith judgment and in consultation with the pregnant person, a pregnant person has: a physical medical condition or complication of pregnancy that poses a risk of infection, bleeding, or otherwise makes continuing a pregnancy unsafe for the pregnant person; a physical medical condition that is exacerbated by pregnancy, cannot be effectively treated during pregnancy, or requires recurrent invasive intervention; and/or a fetal condition where the fetus is unlikely to survive the pregnancy and sustain life after birth.

299. Plaintiffs have sued the State and the relevant state agencies, and that they seek to have this Court determine the validity of Texas's abortion bans as applied in circumstances arising from emergent medical conditions. Therefore, the State and its agencies are necessary parties to this suit and governmental immunity does not apply.

CLAIM II: ULTRA VIRES

300. The allegations in paragraphs 1 through 299 above are incorporated as if fully set forth herein.

301. A state office may not act without legal authority. *See, e.g., City of El Paso v. Heinrich*, 284 S.W.3d 366, 372 (Tex. 2009).

302. Any official's enforcement of Texas's abortion bans against any physician who provides an abortion to a pregnant person after determining that, in the physician's medical judgment, the pregnant person has a physical emergent medical condition for which abortion would prevent or alleviate a risk of death or risk to their health (including their fertility) would be inconsistent with the Emergent Medical Condition Exception to Texas's abortion bans and therefore would be *ultra vires*.

303. Plaintiffs have sued the Defendant state officials in their official capacities, and they seek prospective relief other than the recovery of monetary damages. Therefore, governmental immunity does not apply.

CLAIM III: SECTION 19 RIGHTS OF PREGNANT PEOPLE

304. The allegations in paragraphs 1 through 303 above are incorporated as if fully set forth herein.

305. Under the Texas Constitution, "[n]o citizen of this State shall be deprived of life, liberty, property, privileges, or immunities, or in any manner disfranchised, except by the due course of the law of the land." Tex. Const. art. I, § 19.

306. To the extent Texas's abortion bans bar the provision of abortion to pregnant people to treat emergent medical conditions that pose a risk to pregnant people's lives or health (including their fertility), the bans violate pregnant people's fundamental rights under Article I, § 19 of the Texas Constitution.

307. Thus applied, Texas's abortion bans do not serve a compelling or important state interest and are not sufficiently tailored to serve any compelling interest.

308. Thus applied, Texas's abortion bans also lack any rational relationship to protecting life, health, or any other legitimate state interest.

309. Plaintiffs seek a declaratory judgment that Article I, § 19 of the Texas Constitution guarantees a pregnant person the right to an abortion where the pregnant person has an emergent medical condition that poses a risk of death or risk to their health (including their fertility), and an abortion would prevent or alleviate such risk.

310. Any official's enforcement of Texas's abortion bans as applied to a pregnant person with an emergent medical condition for whom an abortion would prevent or alleviate a risk of

death or risk to their health (including their fertility) would be inconsistent with Article I, § 19 of the Texas Constitution and therefore would be *ultra vires*.

CLAIM IV: EQUAL RIGHTS OF PREGNANT PEOPLE

311. The allegations in paragraphs 1 through 310 above are incorporated as if fully set forth herein.

312. Under the Texas Constitution, "[a]ll freemen, when they form a social compact, have equal rights, and no man, or set of men, is entitled to exclusive separate public emoluments, or privileges, but in consideration of public services." Tex. Const. art. I, § 3.

313. Texas does not prevent non-pregnant people or people unable to get pregnant from accessing critical medical treatment nor force them to unnecessarily suffer severe illnesses and injuries and undergo mental anguish.

314. To the extent Texas's abortion bans bar or delay the provision of abortion to a pregnant person with an emergent medical condition that poses a risk of death or risk to their health (including their fertility), while allowing non-pregnant people and people unable to get pregnant to access medical treatment for emergent medical conditions, Texas's abortion bans violate pregnant people's right to equal rights.

315. Thus applied, Texas's abortion bans do not serve a compelling or important state interest and are not sufficiently tailored to serve any compelling interest.

316. Thus applied, Texas's abortion bans also lack any rational relationship to protecting life, health, or any other legitimate state interest.

317. Plaintiffs seek a declaratory judgment that Article I, § 3 of the Texas Constitution guarantees a pregnant person the right to an abortion where the pregnant person has an emergent medical condition that poses a risk of death or risk to their health (including their fertility), and an abortion would prevent or alleviate such risk.

318. Any official's enforcement of Texas's abortion bans as applied to a pregnant person with an emergent medical condition for whom an abortion would prevent or alleviate a risk of death or risk to their health (including their fertility) would be inconsistent with Article I, § 3 of the Texas Constitution and therefore would be *ultra vires*.

CLAIM V: EQUALITY BASED ON SEX FOR PREGNANT PEOPLE

319. The allegations in paragraphs 1 through 318 above are incorporated as if fully set forth herein.

320. Under the Texas Constitution, "[e]quality under the law shall not be denied or abridged because of sex, race, color, creed, or national origin." Tex. Const. art. I, § 3a.

321. To the extent Texas's abortion bans bar or delay the provision of abortion to a "woman known to be pregnant" to treat an emergent medical condition that poses a risk of death or risk to their health (including their fertility), while allowing other people to access medical treatment for emergent medical conditions, Texas's abortion bans deny pregnant women equality because of sex.

322. To the extent the Texas's abortion bans are based on gender stereotypes that a woman's primary role is to birth children and be a mother, they constitute discrimination because of sex.

323. Thus applied, Texas's abortion bans do not serve a compelling or important state interest and are not sufficiently tailored to serve any compelling interest.

324. Thus applied, Texas's abortion bans also lack any rational relationship to protecting life, health, or any other legitimate state interest.

325. Plaintiffs seek a declaratory judgment that Article I, § 3a of the Texas Constitution guarantees a pregnant person the right to an abortion where the pregnant person has an emergent

medical condition that poses a risk of death or risk to their health (including their fertility), and an abortion would prevent or alleviate such risk.

326. Any official's enforcement of Texas's abortion bans as applied to a pregnant person with an emergent medical condition for whom an abortion would prevent or alleviate a risk of death or risk to their health (including their fertility) would be inconsistent with Article I, § 3a of the Texas Constitution and therefore would be *ultra vires*.

CLAIM VI: SECTION 19 RIGHTS OF PHYSICIANS

327. The allegations in paragraphs 1 through 326 above are incorporated as if fully set forth herein.

328. Under the Texas Constitution, "[n]o citizen of this State shall be deprived of life, liberty, property, privileges, or immunities, or in any manner disfranchised, except by the due course of the law of the land." Tex. Const. art. I, § 19.

329. Section 19 guarantees Texas-licensed physicians the right to practice their profession by providing abortion to their pregnant patients to treat emergent medical conditions that the physician determines pose a risk to the pregnant person's life or health (including their fertility).

330. To the extent Texas's abortions bans bar or delay physicians from providing abortion to treat emergent medical conditions that pose a risk to a pregnant person's life or health (including their fertility), Texas's abortion bans violate Texas-licensed physicians' rights under § 19.

331. Thus applied, Texas's abortion bans do not serve a proper legislative purpose, there is no real and substantial connection between a legislative purpose and the language of the abortion bans as those bans function in practice for patients with emergent medical conditions, and Texas's

abortion bans work an excessive burden on Texas-licensed physicians treating such patients relative to their purpose.

332. Thus applied, Texas's abortion bans also lack any rational basis.

333. Plaintiffs seek a declaratory judgment that Article I, § 19 of the Texas Constitution guarantees Texas-licensed physicians the right to provide an abortion to a pregnant person to treat an emergent medical condition that the physician determines poses a risk to the pregnant person's life or health (including their fertility).

334. Any official's enforcement of Texas's abortion bans as applied to a Texas-licensed physician who provides an abortion to a pregnant person to treat an emergent medical condition that the physician determines poses a risk to the pregnant person's life or health (including their fertility) would be inconsistent with Article I, § 19 of the Texas Constitution and therefore would be *ultra vires*.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs ask this Court:

A. To enter a judgment against Defendants granting appropriate declaratory relief to clarify the scope of the exception to Texas's abortion bans consistent with the Texas Constitution;

B. To enter a judgment against the Defendant state officials that enforcing Texas's abortion bans contrary to the Court's declaration regarding their scope would be *ultra vires*;

C. To enter a judgment that Texas's abortion bans, as applied to pregnant people with emergent medical conditions and Texas-licensed physicians treating such patients, violate the Texas Constitution;

D. To issue permanent injunctive relief that restrains Defendants, their agents,

servants, employees, attorneys, and any persons in active concert or participation with Defendants, from enforcing Texas's abortion bans or instituting disciplinary actions related to alleged violations of the abortion bans in a manner violating the court's judgment;

E. To retain jurisdiction after judgment for the purposes of issuing further appropriate injunctive relief if the Court's declaratory judgment is violated; and

F. To such other and further relief as the Court deems just and proper.

Dated: March 6, 2023

Respectfully submitted,

/s/ Austin Kaplan

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Exhibit A

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The Texas Senate

Bryan Hughes

Committees on:
State Affairs, Chair
Education
Jurisprudence
Natural Resources &
Economic Development
Nominations
Redistricting

August 4, 2022

Executive Director Brint Carlton, JD
Texas Medical Board
333 Guadalupe Street
Tower 3, Suite 610
Austin, Texas 78701

Re: Concerns over allegations received involving the potential corporate practice of medicine and patients experiencing pregnancy complications

Dear Executive Director Carlton:

It has come to my attention that the Texas Medical Association has received and notified the Texas Medical Board of complaints alleging potential violations of Texas' prohibition on the corporate practice of medicine.[1] Such complaints include the allegations that hospitals, their administrators, or even their lawyers may be wrongfully prohibiting or seriously delaying physicians from providing medically appropriate and possibly life saving services to patients who have various pregnancy complications.[2] These complaints arise from confusion or disregard of the law in Texas since the ruling by the United States Supreme Court on *Dobbs v. Jackson Women's Health Organization* and must be corrected.

One mentioned example involves the interference by at least two hospitals of care for premature ruptures of membranes and forcing these patients to be sent home to miscarry without proper pain management or care being provided at the hospital. Another egregious example involves the allegation that a hospital instructed a physician to turn away a pregnant mother diagnosed with an ectopic pregnancy until it ruptured. These disturbing allegations of the prohibited practice of medicine by laypersons and malpractice by acquiescent physicians must be investigated and if they are occurring, stopped.

Pregnancy complications such as these should be swiftly and reasonably treated to prevent or address a medical emergency determined by the physician.[3] "Medical emergency" is defined under Texas Health and Safety Code 171.002(3) to mean "a life-threatening physical condition aggravated by, caused by, or arising

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[1] See, e.g., 22 TAC §177.17(a) stating, in part, "The corporate practice of medicine doctrine is a legal doctrine, which generally prohibits corporations, entities, or non-physicians from practicing medicine. The prohibition on the corporate practice of medicine is based on numerous provisions of the Medical Practice Act, including §§155.001, 155.003, 157.001, 164.052(a)(8), (13), and 165.156."

[2] Letter sent to the Texas Medical Board on behalf of the Texas Medical Association on July 13, 2022 notifying the Board of these complaints.

[3] Other pregnancy complication that a physician could determine rise to the level of a "medical emergency" are ectopic pregnancies, preterm premature rupture of membranes, pre-eclampsia, hemorrhaging, strain on the mother's heart, or peripartum cardiomyopathy. This is a non-exhaustive list.

from a pregnancy that, as certified by a physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed." This definition has not changed.

Senate Bill 8, The Heartbeat Act, expressly allows for a physician to perform or induce an abortion "if a physician believes that a medical emergency exists...."[4] House Bill 1280, the Trigger Bill, also provides an express exemption to prosecution where a physician "in the exercise of reasonable medical judgment, the pregnant female on whom the abortion is performed, induced, or attempted has a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that places the female at risk of death or poses a serious risk of substantial impairment of a major bodily function unless the abortion is performed or induced."[5]

The definition of abortion also provides guidance as to what is not a violation of Texas law: "The term does not include birth control devices or oral contraceptives. An act is not an abortion if the act is done with the intent to save the life or preserve the health of an unborn child; remove a dead, unborn child whose death was caused by spontaneous abortion; or remove an ectopic pregnancy."[6]

Texas law makes it clear that a mother's life and major bodily function should be protected. Any deviation, such as these allegations, should be investigated as potential malpractice and a non-physician (including hospitals) instructing a physician to act should be investigated as a prohibition on the corporate practice of medicine.

I respectfully request that the Texas Medical Board issue guidance on this issue and investigate these allegations.

Sincerely,

Bryan Hughes

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[4] Texas Health and Safety Code Sec. 171.205(a), SB 8, 87th Leg.
[5] Texas Health and Safety Code Sec. 170A.002, HB 1280, 87th Leg.
[6] Under Texas Health and Safety Code Sec. 245.002(1): "Abortion" means the act of using or prescribing an instrument, a drug, a medicine, or any other substance, device, or means with the intent to cause the death of an unborn child of a woman known to be pregnant. The term does not include birth control devices or oral contraceptives. An act is not an abortion if the act is done with the intent to:

(A) save the life or preserve the health of an unborn child;
(B) remove a dead, unborn child whose death was caused by spontaneous abortion; or
(C) remove an ectopic pregnancy.

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